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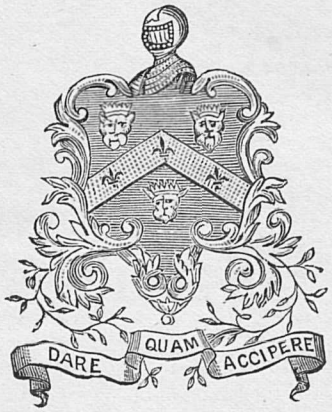

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A STUDENTS' JOURNAL OF HOSPITAL NEWS, MEDICINE, AND SURGERY.

VOL. III.—NEW SERIES.

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Clinical Lecture.

By DR. WILKS.

The first case touched upon was that of a woman with heart disease, complicated with ascites and Bright's disease, who had been admitted on the previous Wednesday, and had died on Friday.

Three points of great interest were to be noted in the case:—

1. The *ductus arteriosus* was patent as a canal just large enough to admit a thick probe: it was obstructed at the pulmonary end by a fibrinous mass, probably recent.

2. Although the *mitral* valve was much thickened and contracted, and from the severe symptoms evidently inefficient, no *bruit* was heard during life. The heart's action was, however, rapid and irregular, and Dr. Wilks had expressed an opinion that there must be mitral disease.

3. All the cardiac valves were more or less diseased, though the *mitral* most so. Had the disease commenced in the mitral, and that of the other valves followed? Was the disease on the right side congenital and that on the left side acquired during life? Had the disease of all the valves commenced and proceeded *paripassu?*

In commenting on the case, Dr. Wilks expressed himself strongly on the impropriety of doubting altogether the efficacy of drugs, because by them we are unable to arrest acute diseases. In chronic diseases we can often do much by medicinal treatment and regulation of diet, and more than in any other chronic diseases, in those of the heart. Over and over again in hospital and in private practice, we meet with cases in which a patient is sinking lower and lower from weak, irregular action of the heart, and consequent dropsy, he is perhaps at the point of death, the doctor comes in, orders digitalis, or belladonna, or it may be ammonia and steel, and the man rallies at once, and perhaps has his life prolonged for several years.

Dr. Wilks then passed on to an interesting case of nervous disease following measles. The patient (Clinical No. 23, now in Mary Ward) is a fine healthy boy of five years of age. He is unable to speak, and has difficulty in protruding his tongue, and also in swallowing. He is unable to stand, owing to weakness of both legs, but lies in bed with his mouth open, and both hands flexed on the forearms, the fingers and thumb also being flexed on the palms, particularly on the right side. The facial muscles are not paralysed, and the boy has a very intelligent appearance, and seems to understand all that is said to him.

As regards his *history*, he had a very mild attack of measles about four months ago; the weakness in the legs followed soon after, and he afterwards lost his speech, and the contraction of the hands came on.

Nervous affections after measles are very uncommon, and are not even referred to in many standard works. They are interesting on account of the possibility of their arising from some tubercular mischief of the brain or cord; the development of tubercles in the lungs being a not uncommon result of measles.

The most important symptoms in this case are (1) the contraction of the hands; (2) the paralysis of the muscles of the tongue and palate, and the weakness of the legs.

What does the contraction of the hands and fingers indicate? Is it spasm? Or is it a permanent organic contraction of one set of muscles following paralysis of their opposers? If the spasm relax during sleep, the former is probably the efficient cause; but if not, the latter.

Spasm is a physiological process, and it requires a healthy cord for the production of spasm. It may result either from extreme excitability of the nervous centres, as in epilepsy and tetanus; or from some continual cause of irritation. The former cannot last for any length of time, and, therefore, if we have a spasm which is of long standing, we may be sure it depends on irritation. Thus,—in what is called "membranous irritation," the cord is healthy, and the cause of spasm is the chronic process of irritation in which the nerves, as they enter the cord, are involved, as a result of the meningeal inflammation. In a similar manner the cause of irritation may act on the surface of the brain, some syphilitic deposit for instance, or on the corpus striatum, or even on the afferent nerve to some set of muscles. But in these cases only one side is affected, whereas in that of the boy before us both arms are contracted; so that we must account for the spasm by some irritation involving both motor tracts.

But, besides these evidences of irritation, the patient is suffering form partial paralysis of the facial, glossopharyngeal, and hypoglossal nerves. But only a *part* of the facial nerve is paralysed, viz., its branches to the palate muscles; its facial portion is not affected. This gives us an illustration of the fact that there are special centres for special functions, and that the whole of the filaments of a nerve, such as the facial, do not come off from the same part of the central organ. To have complete paralysis of all parts of the facial we must have disease of, or pressure on, the nerve trunk.

Now, as to the *diagnosis*.—The paralytic symptoms would lead us to suspect that there is some disease about the nuclei of the fourth ventricle, and extending to the motor tract on either side. But we are met with the difficulty that the spasm (if such it be, for there is a doubt whether the contraction relaxes during sleep) cannot be accounted for by the disease, and we must suppose, in addition, some membranous irritation of the same part. But, if there be an organic contraction of the flexors of the hands and fingers and no true spasm, the case is much simplified, and the disease in the medulla is sufficient to account for all the symp-

toms. [On further enquiry it appears that the contraction does not in any degree relax while he is asleep.]

Such an organic contraction is seen in talipes equinus following infantile paralysis. During the continuance of the paralysis the feet *naturally* assume a position of extreme flexion, such as would be produced by contraction of the tendo Achilles. This may be readily exemplified by hanging up a dead body, when the feet dangle in this position. The limbs constantly remaining in this position during the disease, the muscles become permanently adaped to such a position, and the deformity results.

Some one suggested at the bedside that this was a case of tetany or tetanilla; but, in the latter affection, the contraction of the fingers takes a different form, is only temporary, and is accompanied by pain.

Clinical Surgery.

STRICTURE OF URETHRA. Mr. BRYANT.

The subject is an important one, as coming before us so constantly in every-day practice. Stricture, then, is an obstruction depending upon some change in the walls of the urethra itself. Its causes may be classed under the following heads:—

1.—Inflammatory induration of the mucous and submucous tissue of the urethra. Organic stricture.

2.—The contraction of cicatricial matter in a wounded urethra. Traumatic or cicatricial stricture.

With respect to the causation of the first form, we must remember that about half the cases give no history of gonorrhœa, so we must look further for a cause. Probably some long continued and scarcely noticed bruising operates frequently. Witness the marked frequency of stricture amongst cavalry soldiers. The causation of traumatic stricture is obvious. An organic stricture may go on contracting for years without exciting any attention, retention of urine frequently being the first symptom the patient notices. As an exciting cause of retention, you may be told of cold, excess in drinking, or of an over-distended bladder. The reason of the sudden occurrence of retention is to be found in spasm of an already strictured urethra. Nevertheless, spasmodic stricture does not occur *per se*. As an analogue in other organs one may instance the excessive amount of spasm which results from even a slight ulceration in the œsophagus or pharynx. Amongst the first symptoms which, to the eye of an experienced surgeon, suggest examination by catheter, we have frequent micturition. This is due to irritability, excited by an inflammatory process following over-distension. Later, more or less thickening of the urethra behind the stricture will take place, and in the perinæum a distinct induration will be felt. Following this you may get perineal abscess. This is at first, however, rather a local extravasation, confined by inflammatory material, than a true abscess, although such a condition follows. More or less ulceration has followed the distension of the urethra behind the stricture, and a slow percolation of urine through its wall results. Finally, a decided perforation occurs, and we have the condition of acute extravasation, a most serious complication. Cystitis and an inflammatory condition of kidney eventually follow the severe backward pressure. A kidney incapable of performing its work will be a cause of dyspeptic symptoms, often very marked in stricture cases.

Varieties of stricture.

1.—Annular, or narrow bridle stricture.

2.—Ribbon stricture, perhaps half or three-quarters of an inch in diameter.

3.—Bands stretching across the urethra. Inflammatory.

Seat of stricture.—Organic strictures are most frequently found at junction of membranes and spongy portions. This is the most moveable part, and the most liable to stretching. Next most frequent position is anterior end of bulb. Traumatic strictures are to be found anywhere. At times strictures are multiple.

Treatment of stricture.—Turns more upon its complications than upon the affection itself. Traumatic stricture is much more intractable than the organic form.

1.—In simple uncomplicated stricture of recent standing, dilatation is the best treatment. This not only mechanically dilates the constriction, but, by continuous pressure, promotes the absorption of inflammatory products. No force must be used, but the largest instrument the canal will accept must be passed. Should no irritation of bladder or urethra follow, it may be left *in situ* until the next day, and then replaced by a larger catheter, otherwise four or five hours may suffice. With patients who insist upon following their occupations, the catheter may be passed at night and withdrawn in the morning. A fortnight of the persistent plan should be sufficient. Intermittent dilatation is a longer process.

Forcible dilatation is rarely applicable and often very injurious, extravasation of urine through the lacerated mucous membrane being a formidable danger. It converts an organic into a traumatic stricture, the lacerated mucous membrane throwing out contractile cicatricial material. Frequent catheterism is required for a long time to resist this.

Internal urethrotomy. A good operation in exceptional cases, especially of multiple strictures. Constant dilatation is again necessary after this operation.

External urethrotomy is applicable to those cases of simple stricture (usually found in irritable subjects) which rapidly contract after dilatation. The complications requiring it are those due to extravasation in some form. Never lay open a perineal abscess

without at the same time dividing the stricture. In extravasation extensively diffused, many other incisions may be required. Thus far cases in which a guide can be passed through the stricture have been dealt with, but in a more severe form no guide can be passed, and perineal section, properly so-called, is required. In one form a largely dilated urethra forms a guide, and it is well to pass a guide to the stricture and cut down upon the end of it. In the worst forms Cock's operation, in which none but anatomical guides are available, is indicated. Operation described.

CASE OF ACUTE GLOSSITIS.

UNDER THE CARE OF MR. DURHAM.

November 14th. T. T. æt. 11, a Schoolboy, was admitted into Lazarus Ward, suffering with the above disease.

Family history, good; no history of Syphilis in the family.

The patient himself has had measles and small pox.

On Monday, November 12th, a hard swelling came round the chin, attended with a good deal of shooting pain, extending to the right ear. Linseed meal and bran poultices were applied, which seemed to ease the pain.

On the 14th the pain became so great, and the tongue so œdematous, that he was unable to take even fluids, and was brought to the hospital for relief.

There is no history of any wound in the tongue.

On admission.—Patient is a thin delicate looking boy, with a countenance expressive of great pain. The tongue is very œdematous and painful, and protrudes from the mouth beyond the lips. There is a hard mass of glands under the floor of the mouth. He is unable to take any food, even fluids.

Soon after admission, three longitudinal incisions were made on the dorsum of the tongue, and a very small amount of pus discharged. Evening temperature, 100·6°: Pulse, 118,

November 15th, 3.40 p.m. — Temperature, 100·°: Pulse, 118, Three leeches applied under the chin. Patient slightly delirious. Chloroform was then given, and two more incisions made on the dorsum of the tongue. A good deal of thick pus has discharged since.

November 16th. Morning.—Temperature, 100·6°: Pulse, 132. Skin, dry. Patient very restless. 3 p.m.—Temperature, 100·4°: Pulse, 110. Feels more comfortable. ℞ Quiniæ Disulph. Ver. gr. ij. 4 tis. horis. Succi limonis recentis ʒ ij. To take wine ʒ iv. Evening.—Hemlock and bread poultices applied under the chin.

November 17th.—Patient is not so restless. Temperature, 98·8°.

November 19th.—Temperature, 97·2°: Pulse, 86. The tongue has returned to its natural size. No pain. Patient has eaten a mutton chop for his dinner.

November 20th.—Going on very favourably.

November 25th.—Patient up about the ward.

November 28th.—Left the hospital cured.

DR. GEORGE MACKENZIE BACON.

We have much pleasure in observing that a former pupil of Guy's Hospital has received a high honour from the University of Cambridge, which has conferred upon him its M.A. degree, in consideration of his services to its students, in acknowledgment at the same time of his merits, and a recognition of the value of medical science.

We extract the following from the *Times* newspaper.

"Cambridge, Nov. 1st.

"At a congregation this afternoon, the Public Orator (Mr. J. E. Sandys) attended for the purpose of presenting to the Vice-Chancellor Mr. George Mackenzie Bacon, M.D., St. Andrew's, the resident medical superintendent of the Cambridgeshire and Isle of Ely Lunatic Asylum, to whom had been granted the honorary degree of Master of Arts. In the course of an eloquent Latin speech (which we give below), the Public Orator, after noticing the fact that in the ancient world Athens alone set up in her market place an altar to the Goddess of Pity, and that even Athens knew of no hospital, remarked on the vast improvement that even recent times had witnessed in the treatment of pauper lunatics. Referring to Dr. Bacon, he drew attention to the valuable services he had gratuitiously rendered for the last nine years to the medical students of the University, by affording them facilities for clinical instruction in diseases of the brain.

The following is the text:—

"Dignissime domine, domine Procancellarie, et tota Academia-Inter antiquos memoratu dignum videbatur, Athenienses solos in foro suo aram Misericordiae posuisse; sed ne Athenis quidem domus publico sumptu conditæ miseris et corpore aegro laborantibus hospitio pan tebant. Quanto igitur humanius, quanto arti medicae excolendae accomodatius, nos, recentium quoque temporum immanitater exuta, etiam qui mente capti sunt, pauperes et calamitosos, summa cura tractandos et utili manuum labore exercendos in securas sedes secludimus, asyli nomen ab antiquis illis mutuatas, qui rom ipsam nunquam habuerunt. Talis autem asylis haud procul ab urbe nostra positi praeses adest hodie, vir non modo peregre in Italia de investigandis rebus medicis bene meritus, sed (et ad propiora veniamus) in hac etiam Academia eo praesertim nomine laudandus, quod iam novem annos alumnis nostris medicinæ studiosis ultro concessit ut eos qui curae suae traditi sunt identidem invisirent, et nulla habita emolumenti ratione suae experientiæ fructus perciperent.

"Ipse Hippocrates medicinæ pater discipulos suos jurejurando obstrinxisse dicitur, sese magistri sui filiis artem medicam nulla accepta mercede esse traditurus; quanto autem præstantius est hunc Hippocratis discipulum, nullo jurejurando devinctum sed sua sponte motum, non jam in suorum præceptorum progeniem sed in alienæ Academiæ adulescentes tantum beneficium gratis contulisse.

"Tu vero, qui alumnis nostris magno cum fructu medicæ

artis magister sponte exstitisti, honoris causa artium magister nobis esto.

"Duco ad vos Georgium Mackenzie Bacon."

Dr. Bacon was then admitted to the degree of M.A. in the usual manner.

STATISTICS OF SECONDARY HÆMORRHAGE IN CASES OF AMPUTATION DURING THE LAST TEN YEARS AT GUY'S.

COLLECTED BY MR. JOHN POLAND, BEING PART OF HIS PAPER READ BEFORE THE GUY'S PHYSICAL SOCIETY.

1867.

Forty-two amputations, with two deaths before the end of first day.

Silk Ligature used in 31 of these cases—viz., Thigh (13), Leg (8), Foot (1), Arm (7), Forearm (2). In 3 of these Secondary Hæmorrhage took place—Thigh (7th and 8th days)' Arm (58th day).

Acupressure used in 9 amputations—Thigh (3), Leg (5), Wrist (1). In 3 of these Secondary Hæmorrhage—Thigh (5th day), Leg (2nd), Wrist (3rd).

1868.

Forty-one amputations; four deaths in few hours.

Silk Ligature used in 22 cases, viz., Thigh (11), Leg (1), Knee (2), Foot (4), Shoulder, Arm, Forearm, and Wrist, 1 each. In two of these Hæmorrhage—Thigh (5th day), Shoulder (7th day).

Acupressure used in 9 cases, viz., Thigh (2), Leg (3), Foot (2), Forearm and knee, 1 each. In 3 of these Hæmorrhage—Thigh (8th day), Leg (2nd day), Knee (3rd).

Torsion used in 6 cases—Thigh (3), Knee (1), Forearm (2).

1869.

Twenty-nine amputations; one death before 5th day.

Silk Ligature used in 7 cases, viz., Thigh (4), Knee (3), Leg(2).

Acupressure used in 1 of Thigh.

Torsion used in 20 cases, viz., Thigh (7), Leg (5), Foot (3), Forearm (2), Knee, Arm, and Elbow, 1 each. In two of these Secondary Hæmorrhage—Thigh (10th day), Leg (3rd).

1870.

Fifty amputations: eight deaths before the 4th day.

Silk Ligature used in 4 cases—Thigh (2), Leg (2).

Torsion used in 38 cases, viz., Thigh (14), Leg (11), Foot (4), Knee (5), Elbow, Forearm, Knee, and Shoulder, 1 each. In 2 of these Secondary Hæmorrhage—Shoulder (6th day), Elbow (6th).

1871.

Sixty amputations; Eleven deaths before 6th day.

Torsion used in 46 cases, viz., Thigh (23), Leg (9), Knee (5), Foot (3), Knee (4), Shoulder and Forearm, 1 each. In one of these Secondary Hœmorrhage—Leg (5th and 8th day).

Catgut Carbolized Ligature in 2 cases, viz., Hip and Knee.

Artery Constrictor used in 1 of Arm.

1872.

Fifty-one amputations; six deaths before 6th day.

Torsion used in 44 cases, viz., Thigh (21), Leg (11), Arm (4), Knee (2), Forearm (3), Shoulder, Wrist, and Foot, 1 each. In 3 of these Secondary Hæmorrhage—Thigh (18th day) Leg, (4th, 14th, and 16th).

Gut Ligature used in 1 of Knee.

1873.

Forty-three amputations; eleven deaths before 8th day.

Torsion used in 27 cases, viz., Thigh (8), Leg (4), Knee (3), Shoulder (2), Arm (4), Forearm (2), Foot (2), Wrist (1).

Carbolised Gut Ligature used in 5 cases—Thigh (2), Knee, Leg, and Arm, 1 each.

No case of Secondary Hæmorrhage.

1874.

Eighty-five amputations; ten deaths before the 5th day.

Torsion used in 65 cases, viz., Thigh (24), Leg 15, Knee (9), Forearm (6), Arm (4), Elbow, (1), Hip, Foot, and Shoulder, 2 each. In one of these, Secondary Hæmorrhage Hip on 4th day.

Carbolised Gut Ligature in 10 cases, viz., Leg (4), Knee (2), Hip, Foot, Arm, and Wrist, 1 each.

1875.

Sixty-seven amputations: eight deaths before 6th day.

Torsion used in 51 cases, viz., Thigh (18), Knee (4), Leg (7), Arm (12), Forearm (5), Foot (3), Hip (2). In 3 of these, Second Hæmorrhage—Thigh (18th, 5th, and 6th days), Forearm (16th and 21st).

Carbolised Gut Ligature used in 8 cases, viz.,Thigh (3), Shoulder (1), Hip and Foot, 1 each. In 2 of these, Secondary Hæmorrhage from Hip on 7th and 4th days.

1876.

Seventy-five amputations; twelve deaths before 5th day.

Torsion in 58 cases, viz., Thigh (16), Leg (10), Forearm (11), Foot (7), Knee (4), Arm (8), Hand (1), Hip (1). In 2 of these, Secondary Hæmorrhage—Thigh (10th day), Foot (29th, 30th, and 35tn days).

Carbolised Gut Ligature used in 5 cases, viz., Foot (2), Thigh, Knee, and Leg, 1 each.

Total number of amputations during the 10 years, 543; of these there were 73 deaths within a few hours or the first few days, and are not included in the following figures, because in them the efficiency of the mode of arresting hæmorrhage could not have been fairly tested, with the exception of Acupressure; 64 cases in which Silk Ligature was emplowed, and among them 5 cases of Secondary Hæmorrhage, 1 in every 12·8, or 7·812 per cent.

19 of Acupressure, in 6 of these there was Secondary Hæmorrhage; 1 in every 3·1 cases, or 32·63 per cent.

355 of Torsion, in 14 of these there was Secondary Hæmorrhage; 1 in every 25·3, or 3·66 per cent.

31 of Carbolised-gut Ligature, 2 cases of Secondary Hæmorrhoge; 1 in every 15·5, or 6·45 per cent.

The above cases were collected after a Examination of the Surgical Clinical Reports and Post mortem Records. They show a somewhat greater frequency of occurrence of Secondary Hæmorrhage after amputation, than what is generally stated to occur. Here, every case of Secondary Hæmorrhage has been included; those cases in which the patients afterwards recovered, as well as those in which they died, as an immediate result of the Hæmorrhage. Whereas in many of the statistics that have been published, only those cases are included in which the patient succumbed immediately, or soon after the occurrence of the Hæmorrhage. There are other fallacies in the above statistics.

In the first place, for comparison, we should have corresponding numbers, and the same sort of amputations in each case; and, of course, as great a number as possible, and the patients under similar conditions.

Secondly, in respect to the old Silk Ligature. Secondary Hæmorrhage at that time was not at all uncommon, so that probably only the very worst cases were recorded; therefore we should have have had a still proportion of cases than the above.

Also the frequency of Secondary Hæmorrhage in the cases of Carbolised catgut is great, because in most of them, this form of ligature was used on account of the impossibility of using, or failure of Torsion, from a diseased state of the arteries, &c.

RHYTHMIC CONTRACTIONS OF THE HEART.

G. S. MAHOMED.

"The causes of the continuous rhythmical contractions of the intracardiac nerve-centres is wholly unknown to us."

So says Hermann, and inasmuch as Sir James Paget's

theory of rhythmic nutrition has not been generally received as a satisfactory explanation, I conclude that the question is still an open one, and I venture to submit the following thoughts on the subject.

The accepted theory of respiratory rhythm is that the venous blood supplied to the medulla acts on it as a stimulus sufficient to cause the rhythmic respirations. Now these phenomena (the cardiac and respiratory rhythm) are in some respects analogous since they are both rhythmic, and as I think both dependent on the blood supply of their respective ganglia. First let us consider the blood supply of the heart. It is derived from the coronary artery, and this artery is filled with each contraction of the heart, or rather of the aorta; and of course, not only the muscular part, but the ganglia themselves receive their blood from this source. And as in other parts, the blood thus supplied will shortly become venous, and a fresh supply of arterial blood be rendered necessary. For there is no reason to suppose that ganglia do not deoxidize blood, inasmuch as the blood supplied to the spinal cord becomes not less venous (*i. e.*, rich in carbonic acid, poor in oxygen) than that of other parts. (Hermann.)

There is therefore a necessity felt for fresh arterial blood in the ganglia. This necessity is moreover felt immediately at the place of requirement, and also in the organ, the action of which is necessary. For it is felt by the intra-cardiac centres, and is relieved by the contraction of the heart itself. Hence the stimulus is direct and instantaneous; whereas in the phenomenon of respiration the requirement is felt at a distance from the organ which satisfies it.

May it not be then, that—*Each systole of the heart is brought about by the action of the intra-cardiac centres, induced by the demand for fresh blood;* just as the action of the respiratory centre for fresh blood. This theory receives support from the following facts: (*a.*) That in asphyxia the number of heart beats is increased; (*b.*) Because the hearts of cold-blooded animals, when excised, only continue to beat as long as the presence of oxygen is maintained, and (*c.*) from the relation which is maintained in many pathological conditions, where there is either imperfect oxidation or increased deoxidation—between the respiratory and cardiac rhythms. It must be remembered that this theory only applies to the intra-cardiac ganglia probably, and that other differences in the rate of the rhythm are referable to higher and distinct nervous influences affecting the vagus or vasomotor centre.

It may be urged that there is not much difference between the existing theory and that which I have suggested; but in the former case the contraction is supposed to be brought about by the abundance of potential energy, which admits of the organ discharging its functions, whereas in the latter the want of such energy as soon as it is felt brings about a change which fills the requirement. In fact we might consider the stimulus to action, as in the one case, the shout of the reveller, in the other, the cry of the hungry.

Football News.

GUY'S *v.* UNIVERSITY.—(Second 15.)

This match was played at Tottenham Park, Sat., Dec. 8th Guy's won the toss, and took the kick off. The kick off was well followed up, and the first scrimmage was close to the University Goal, after a good deal of brisk play on both sides, Guy's *forwards* worked the ball close to to the goal line, soon after this Fasken kicked the ball over the line, and following up his kick obtained a try, the place-kick was unsuccessful, and University touched the ball down. Long now ran in twice in quick succession and obtained two more lines, both of which were unsuccessful. Subsequently Trevor dribbled the ball over the goal line, and Lister touched it down, obtaining another try; this time the ball having been brought out it unfortunately changed hands, and the University men charged, but Lister taking the ball dropped a goal. University now kicked off, but were soon driven back to their goal line, and were forced to touch down. Half time was now called, and University kicked off, they were, however, soon driven back to their goal line. When time was called, Lister had obtained two more lines, and Osborne, Bishop, and Dixon also ran in and obtained tries, all of which were unsuccessful. In addition to this University were forced to touch down a great many times. The bad-place kicking of Guy's, may be attributed, firstly, to the little practice the team have had in this particular branch; secondly, to the long grass, unequal ground, and slippery ball. In the tight scrimmages University were decidedly the strongest, but in the loose scrimmages, and behind the scrimmages, Guys' showed their superiority.

University.—Wilson (Capt.), O'Connor, *three-quarter back.* McDonnagh, Griffiths, *quarter-back.* Branson, *back.* Marshall, Shele, Winstanley, Case, Downing, Barker, Yates, Martin, Beddow, Cottrell, *forward.*

Guys.—Pierson (Capt.), Lister, Green, J. L. Jones, Bishop, Osborne, Trevor, Harper, Arnott, Jago, *forward.* Long and Fasken, *quarter-back.* Dixon, *three-quarter back.* Edwards and Lawson, *back.*

NOTES OF THE MONTH.

APPOINTMENTS.—The following appointments were made by the Treasurer on the 28th:—

House Surgeons—Messrs. Wright, Gardner, James, and Judson.

House Physicians—Messrs. Horrocks, Shaw, and Barrs.

It will be seen that this time there are four House Surgeons appointed. They are to hold office for six months, with the exception of the first, who begins with the Surgery, and has only four months. The others commence with two months superintending the Surgical Out-patients, the next two months in the Surgery; and the final two in residence. We hope to give more practical details of this change in our next issue, when the duties have become more clearly defined.

EXAMINATION NEWS.—University of London. The following have recently obtained the M.D. :—Henry Hetley, W.A. Kidd, B.S., James Arthur Rigby, Mr. Henry Ashby, and Mr. T. S. Morley passed in Logic and Moral Physiology. Mr. L. C. Woolridge of this Hospital has also recently obtained the Batchelor of Science (B. S.)

The following paragraph appeared in the *Standard* of December 10th, 2877:—

"Surgeon Gill distinguished himself greatly in the recent engagements. His horse received a wound from a shell, and he was commended by the Muchir Pasha for dressing the wounded under a heavy fire."

Mr. Gill was a distinguished student when at Guy's. He obtained the second prize of his year both in 1864 and in 1865, and in the latter year he gained also the Treasurer's Gold Medal for Surgery. He was appointed House Surgeon in 1866, and afterwards settled at Wem, in Shropshire, where he held the appointment of Medical Officer of Health, and Coroner, till he left for the war.

The following appeared in the *Times* of December 15th:—

"Mehemet Ali has recommended that a decoration be given the two English doctors, Gill and Murphy, for the courage and devotien they have displayed in the discharge of their duties on the battle field."

We have received the following from Dr. Owen Rees:—

"I am very sorry to find that the *Guy's Gazette* no longer publishes a list of the cases in Hospital. It was very valuable, and I should be so glad to see such entry standing again on its pages."

GUY'S HOSPITAL GAZETTE,
JANUARY, 1878.

WITH the publication of this number we begin the Third Year of the *Gazette* in its monthly form, and on looking back we cannot but think that some progress has been made. The circulation has increased, and now assumes quite respectable proportions. This result is due, in some measure, to old subscribers, when they leave the hospital, still keeping up their subscriptions; but many new names also, chiefly among the junior men, have been added during the last year. The little ship, with its tiny sail, which Mr. LUCAS so eloquently described as being launched out into the mighty deep all alone has weathered a storm or two in its infancy, but we trust it can now go forward with confidence, having got over its early vicissitudes, and having but gained confidence from them.

We do not wish, like our contemporary, the *Student's Journal*, to be more than a local journal—we are essentially Guyite, and as such, of course, the amount of local news must vary each month. Keeping in view the *esprit de corps* among Guy's men, and the great regard they always have for their *Alma Mater*, we have always endeavoured to collect scraps of news, and discuss home matters more fully than is done in the other medical journals; the Guy's *Gazette* must then be the best medium of news for old Guy's men.

This hospital furnishes year by year a large number of valuable cases, many of these of course cannot find their way into the medical journals; so it has also been our custom to publish the most interesting and important of them, as the occasion offers.

As in all cases the reports are made specially for publication, great care is taken in their preparation, and they may be relied on as true statements of facts. This, in itself, constitutes valuable clinical sources of knowledge, which not only proves useful to students at the hospital, but as many old Guy's men have over and over again testified, is likewise much appreciated by senior men who are busy in practice.

Clinical lectures, which are delivered by both physicians and surgeons, are published from time to time; and these, as they often contain the outcome of long and deep experience, are simply invaluable. It is seldom that we are able to give the lecture word for word, but every endeavour is made to get the sense and substance of it, and in many instances the abstract is looked over and added to, or altered, by the lecturer himself.

The questions set at the various examinations too, when obtainable, find a place in our columns, and no doubt prove acceptable and useful to men preparing for the different tests, and interesting to all as showing the character of examinations in these advanced and scientific days.

The monotony of all this strictly medical work is occasionally relieved by flashes from *Pilocereus Senilis* and others. We trust that the former may still endeavour to satiate our unnatural thirst with more "Buttermilk" during the ensuing year.

Lastly, during the winter, an abstract is given of each paper read before the Physical Society, and short reports of the speeches. By this old Guy's men may see the direction of thought in the young blood which is to swell their ranks some day.

We look then with every satisfaction at the work and success which we have achieved during the past two years. The *Gazette*, like publications of many of the Public Schools, has, we believe, become one of the institutions of the Hospital, and we trust that all Guy's men will help to maintain both its value and its circulation.

Physical Society.

Meeting December 1st, 1877, Mr. HARTLEY in the Chair. Mr. W. H. WHITE read a paper on "History of Food in its course through the body."

It was first pointed out that it was chiefly by oxidation of food that potential was converted into kinetic energy, which manifests itself as mechanical work, heat, sound, and electricity. The history of the food was divided into three stages, viz.:—(1) its digestion and absorption; (2) the construction of some of the more important tissues from the absorbed products; (3) the breaking-down of these tissues, and excretion of the waste products.

Digestion was passed over rapidly. Special stress was laid on the threefold action of pancreatic juice, which converts starch into sugar, decomposes fats into fatty acids and glycerine, and converts proteids into peptones. The trypsin first converts the proteid into tyrosin, an aromatic body whose constitution is exantialbumenose and hemialbumenose, which give rise to antipeptone and hemipeptone, which latter is further decomposed into leucin or amidocaproic acid and pressed in its name oxyphenylamidopropionic acid.

The glycogen question was then fully discussed.

It was then explained that fats were glycerine, in which one of the hydrogen atoms of the three hydroxyl groups was replaced by radicals of the higher members of the fatty acid series. Four methods were pointed out by which fats might be formed within the body, viz. :—(1) the gastric juice converts lactose into lactic acid, which can be easily converted into Butyric; (2) the succus-extericus converts cane sugar into lactic acid, from which we get Bvtyric; (3) pancreatic digestion produces leucin, a body which can be converted into caproic acid; (4) glycocholic acid splits up into cholic acid and glycocol, taurocholic into cholic acid and taurin. Both glycocol and taurin are connected in constitution to fatty acids.

Proteids were next considered. It was shown that if a large diet of proteid be administered a condition of nitrogenous equilibrium comes on, in which the nitrogen excreted corresponds to that ingested, although at the same time the animal gains in weight by the laying up of fat, whilst the nitrogen is excreted as urea. In some cases the body loses in weight on a proteid diet, as this diet causes increased number of red corpuscles, which means an increased oxidation of the body. An experiment was then quoted in which 130 grammes of proteid matter were taken daily, containing 70 grammes of carbon, of which only 23 were excreted, leaving 47 stored up as fat.

The third and last stage was then discussed.

The breaking down of fats and proteids into carbonic acid, water, and urea was shown to set free the energy by which the body lives. Fats are nearly twice as productive of work as proteids. This led to the urea question. Experiments were quoted which quite disproved Liebig's views that urea is the only and immediate product of muscular metabolism, and that the urea increases *pari passu* with the work done. Muscles contain no urea, although they contain creatine, therefore it it extremely probable that creatine is converted into urea. Some attribute to the renal epithelium this power, whilst some consider that the conversion takes place in the blood. It was conclusively proved that neither of these views were tenable. A theory was put forward which attributed the conversion to the muscles, but the absence of urea from muscle was explained by supposing that the urea was carried away by the blood as soon as found. Reasons were given in support of this view. It was also shown how it was possible on this theory to account for the formation of lactic acid in muscle. Next it was pointed out that perhaps the leucin formed during pancreatic digestion was in the liver converted into urea. This was supported by the facts that the liver contains urea, and there is diminished urea, but increased leucin, in the urine in atrophy of the liver. It was shown that Schullzen's views did not at all help to explain the conversion of leucin into urea.

Lastly, the conversion of uric acid into urea was explained. If uric acid be oxidized in the presence of water it gives up two hydrogen atoms to form dehydroic acid, which, reacting with water, forms alloxan and urea, thus :—$C_5 N_4 H_2 O_3 + 2 H_2 O = C_4 H_2 N_2 O_4 + C A_4 N_2 O$. The alloxan may be further acted on by water, by which we get mesoxalic acid and urea, thus :—$C_4 N_2 H_2 O_4 + 2 H_2 O = C_3 H_2 O_5 + C H_4 N_2 O$.

Meeting, December 15th, 1877, Mr. J. T. HINTON in the Chair. Mr. MAYLARD read a paper on "Physiological Therapeutics."

"Physiological Therapeutics" might be divided into two heads :—(1) The Physiology and Therapeutics of Physical remedies, such as Temperature, Electricity, &c., and (2) The Physiology and Therapeutics of Drugs."

The latter branch was the subject for discussion. A few preliminary remarks were introduced upon the subject generally. Eulogising this particular method of investigation of Therapeutical application from Physiological research as being a system which is tending to revolutionize aad reform the old, and to reinstitute and rebuild a new; briefly, to make medicine a science, and not an art. The subject was treated under the following heads :—

(1) Briefly, its History, following up most carefully, the action of certain general remedies whose Therapeutieal value is dependent upon their physiological action.

(2) Its advantages.

(3) The difficulties with which it is encompassed,

"Concerning its History, we have to recede but a very few years before we meet with that old happy-go-lucky style—if I may so express it—of the enpirical use of drugs. So recent as 30 years ago the real method of investigation appears to have been felt, for Dr. Coupland in his Dictionary of Medicine observes :—'The want of correct ideas as to its physiological action of remedies is one of the most powerful causes of the retardation of Therapeutical Knowledge.' Judging then from its rapid progress in the last few years, from its comparative infancy, 30 years ago, we can place its origin at no remote period." In justice to our ancestors a certain amount of merit was ascribed to the ancient customs of the soothsayers, and to the principles and practices of an old Medical School, the Methodic Sect.

"Of drugs, depending upon their physiological action for their Therapeutical value, Digitalis, Belladonna, Nitrite of Amyl, and Quinine, were introduced as examples," Digitalis, physiology teaches us, prolongs the diastole, hence it is advantageous in mitral obstruction, and injurious in aortic regurgitant, advantageous in the former disease because more time is allowed for the blood to flow through the obstructed mitral orifices, into the slowly distending ventricles, injurious in the latter disease, because the prolonged diastole admits a greater reflux of blood than the insufficiently closed aortic orifice.

Again, physiology has taught us that belladonna produces its effects through the medium of the vagus, hence it is applied in Laryngismus stridulus, and whooping cough, in which conditions irritability of pneumogastric nerve is at the bottom of the phenomena. Nitrite of amyl paralyses the vaso-motor centre, and causes the arteries and bronchial tubes to dilate from the ultimate paralysis of their muscular coats. Hence it is given in anglina pectoris and spasmodic asthma, conditions depending upon muscular contraction of their respective coats. In quinine we have a sample of what physiology has done to further the value of an already existing remedy. Quinine had for some time been used as a remedial in ague. The pathology of ague showed that the cold stage was dependent upon a general contraction of the capillaries; and that quinine had the antagonistic power of controlling this contraction. This led to its uses in so-called nervous asthma, a condition depending probably upon spasmodic contraction of the lung capillaries. (Dr. G. Buchanan.)

In considering the second section of the paper, 'Its Advantages.' "Beyond those which obviously suggest themselves from the preceding remarks, may be mentioned; that the value of a drug is at once substantiated in its action, though this may be modified to some extent in degree. It will no longer be subjected to the variableness of fashion, or to the depressing influences of medical jealousies, prejudices, and other such injurious contentions, all of which formed such formidable impediments in earlier times. Again, we are saved from that indiscriminate use of drugs, those complicated and more or less culinary concocted characteristics of Smellie, Andromachus, and many others; the 'thenaca' of the latter of whom consisted of sixty-one ingredients."

"In turning to the last section of my subject—The Difficulties which it is encompassed—we have to encounter difficulties which are in many cases detrimental to the beneficial effect of every remedy, and cannot, therefore, be considered as peculiarly prejudicial to the particular method of investigation. Others, again, which are absolutely obstructive to the furtherance of science, but are in their season apparent rather than real. The whole foundation of this branch of medical science appears to have had its origin in, and to have obtained most of its most serviceable deductions from, experiments upon the lower animals, and it is upon this point we meet with our greatest obstruction or difficulty. There is a certain body of dogmatic enthusiasts known as Anti-vivesectionalists, whose zeal has overcome their discretion, and to whose feeling enthusiasm, as they would have it, we owe the cause of the present restraint. One of the great arguments of these *feeling* enthusiasts is, that to test the action of the drug upon an animal is useless, inasmuch as the effect produced upon it and man are invariably different. That these deductions are apparent rather than real, and dependent upon the varying susceptibilities of men and the lower animals, I shall proceed to show from the logical reasoning of Wood. These few out of the many conclusions which Wood so logically deduces, are sufficient, I think, to disprove the fallacy of the argument I brought forward, and to quote Dr. Christison's own words upon the subject, 'If the subject be studied more deeply, the greater number of the alleged diversities will prove apparent rather than real.' By this means we may hope to have removed a deliterious, grave, and pernicious impediment to a method of investigation which is truly scientific in its practices, and has already proved so extremely beneficial in its results."

CHRISTMAS IN THE WARDS.

The idea of Christmas being a merry or happy time in the wards of a hospital might appear absurd to those people, who fancy that a hospital is but one vast scene of suffering, and that no light can ever break through its gloomy portals. A visit to Guy's during the Christmas week would soon have dispelled any such delusion. Certainly it is our lot to witness much suffering, but we should remember that here we have the concentration of the greater evils of humanity. We see many of the lesser ones, and sometimes not a few of the greater, outside the wards in the general world. However, let facts speak for themselves, and those of us who were up at the end of last month, saw that the inner world of Guy's was determined to be gay and happy, and that it had succeeded well. Staff and students vied with each other to make it an enjoyable season, and the cheers and happy faces in many of the wards, showed how all this was appreciated.

To begin with the decorations, we may say they were as magnificent as usual, and represented what must have been the labour of many brains and hands, and practised hands too. We were much struck with the taste generally displayed. Scarcely anywhere did we meet with anything gaudy, or otherwise displeasing to the eye. Holly and Ivy were very plentiful, and very good, Sisters and Nurses seem to

be able to make every possible use of them. Festoons and wreaths were evidently fashionable, and very good effects were produced by their help in CORNELIUS, LUKE, MARTHA, NAAMAN, and CLINICAL, A good deal of originality was also displayed, especially in CORNELIUS. where a very pretty grotto-like effect (looking from within) was produced round the entrance door; and in MIRIAM, where the central double fireplace had placed on it a high crimson bank. All the way round this the motto "A Happy Christmas, and a Bright New Year to all" was very well done in raised tapioca letters, while sprigs of fine ivy trailed across and between the letters; above this bank again, rose a mass of dark-green young Fir trees, the whole producing a most striking object in the centre of the ward. A fresh cartoon in LUKE by "Our Special Artist" was, of course, a great attraction. An adequate description of this work of humour and art fails us at this moment; the Surgical Staff are therein immortalised, some of the portraits being remarkably good. A detailed description by our Special Surgical Reporter will be found further on.

In the Medical wards, the decorations on the whole were on a less elaborate scale than in the Surgical. This is to be accounted for by the size of the wards, and by the fact that the Dressers, of course, are on the spot nearly all day, and work hard for their respective wards. But good taste was general, and artificial flowers were made good use of.

In PHILIP, much labour had been expended in wreathing the beds together, and as uniformity of design was strictly adhered to, a goodly effect was obtained in looking down the divisions of this large ward; we were glad to see the large pictures in the centre department well relieved by green wreaths.

In STEPHEN excellent taste was shown; we were glad to see artificial flowers conspicuous by their absence; it was simply "nature unadorned" all throughout. Holly and Ivy cunningly intermixed was the grand resource, and very well was it used. Every bed rail and post had its wreath, every text and picture its bunches at the corners. The gaseliers also were one green luxurious mass. All the four divisions were identical in arrangement, so that symmetry and order were evidently the leading principles.

MARY deserves commendation for the pretty wreaths on the bed rails, and round the medicine stands, a very judicious use of artificial flowers added to, rather than retracted from. the beauty of these.

In ADDISON, where, by the way, an excellent plum pudding was provided, the decorations were tasteful, if not elaborate, plenty of green relieved the long vista of beds on each side.

BRIGHT was modest in its efforts, but none the less did it look light and bright. Well designed bunches of green occupied the centre of each bed rail. We were not so well pleased however with the rather glaring method of decorating the gaseliers.

The EYE WARDS presented a most elaborate system of festoons, the numerous curves of which were mathematically correct, and must have cost a good deal of trouble and labour. A somewhat curious effect was produced in the centre fireplace of RUTH, where a bower of green was constructed, in the middle of this the cast of an infant was placed on some straw, while two angels looked down, one on each side.

CLINICAL, if not the first, certainly ranks among those wards deserving the highest eulogy. We at once recognise the work of practised hands in the white mottoes on scarlet ground which surrounded the fireplace in MIRIAM, surmounted by firs reaching nearly to the ceiling; and with that tasteful uniformity which pervades the whole ward, the same style borders the cornices here and there, and shapes itself to banners on each pillar, and on the numbers over every bed.

JOHN, the sister ward, does not appear to have received so much extraneous attention, excepting in two banners of dark blue, with white letters, which taking them as works of art elicit unqualified praise.

The festoons of holly leaves are tastefully arranged as far as they go, but if we might be allowed to criticise a little less favourably. we should have suggested a continuation round the end of MIRIAM, as there is just something wanting, 'a bringing together,' like a picture perfect in manipulation and detail, but failing as a perfect whole.

N.B.—Y's (Why is) an N like Cleopatra's needle?

Because it won't do turned upside down.

On the Surgical side the Christmas decorations in the wards have by no means been neglected, for, from the SURGERY to SAMARITAN, everyone showed tokens, each one in its particular style, of the determination of its respective Sisters and Dressers to render the wards as cheerful and picturesque as circumstances will allow.

In ACCIDENT, wreaths of green over the pictures, and over each doorway, gave a pleasing effect, whilst over the chief entrance was placed a cleverly wrought coat-of-arms, the quarterings consisted, if we mistake not, entirely of rice, giving an excellent appearance to this end of the ward.

CORNELIUS looked remarkably well, tastefully decorated with green festoons, perhaps a little too heavy, between the beds, and texts and symbolical designs worked in colour. A very fine effect was produced on the north side, where a text, gold letters on a red ground, ran along the whole length of the front ward., which bordered by sprays of fine ivy, was in excellent keeping with the doorway described before. We must not forget to mention that some of the windows were most cleverly "frosted" over. On the whole this was one of the best decorated wards in the hospital.

In CHARITY, besides a profusion of thick green wreaths, intermixed with artificial flowers, we observed several banners, the chief one conveying wishes, in rather tumble-down characters, for Mr. Forster and his Dressers; a more modest one invoked the like for Mr. Davies-Colley and his Dressers. Beneath this was a little sketch of an unfortunate youth suspended in the now popular Sayre's apparatus, undergoing a severe "jacketing" before a quick fire. By the outline of the figure we should infer that the "dinner pad" had not been forgotten! The Christmas tree in this ward is to be specially commended.

MARTHA was well in the front with very effective ceiling festoons of green, intermixed with holly berries between each bed, which, with the rich colours of the

texts at the end of the ward, imparted a warmth and solidity of decoration which must have struck both visitors and patients.

Of the work in LYDIA we are tempted to speak at length, but limited space forbids; suffice it that we mention the rendering of the Christmas greeting, the letters of which, extending the whole round of the ward, formed over each bed a pretty, if rather incomprehensible, ornament. A well laden tree, and Medusa-like window decorations deserve especial notice.

Passing into JOB we find less elaborate, though not less tasteful, decorations, consisting as they do solely of bunches of green over the rail of each bed. Although we believe that the "use of the spray" is not generally approved of in this ward, we are strongly of opinion that the "sprays of the yew" thus disposed, are deserving of all approval, and would hope that they may serve as a nidus for all wandering germs that might otherwise find their way into hip, knee, and elbow joints unrestrained.

NAAMAN was decorated in a style which may be described as severely classical. (Our Special Reporter goes no further than this, because we understand he was afraid of one of the "thin red lines" becoming detached from the ceiling, and twining itself round his neck, so he made a hurried retreat; we therefore continue the report ourselves. Ed. G.H.G.) At first we were somewhat puzzled with the multiplicity of festoons, which were of a much lighter construction than those in other wards, being made up of, alternately, a row of holly berries and leaves, but as we unravelled each set, one by one, and especially when we took a general view from the point, at the junction of the front and back wards, it was impossible not to see the perfect taste and oneness of idea which pervaded the whole. The right hand side, where the festoons formed one continuous line, served well to illustrate what was in the artist's mind.

The numbers were a charming study in themselves, and many other details showed much refinement. Beauty of detail then may be said to be the distinguishing feature in the decoration of this ward. We left it well pleased, having first of all cleared our throats, by a good cough, from an irresistible sensation of cobwebs.

In DORCAS less ambitious efforts were made, but we have the satisfaction of knowing that they were carried out mainly by the patients themselves, under the direction of the Sister.

LUKE, from which we always expect much, contains once more the principal centre of attraction on the Surgical side, viz,, an exceedingly amusing and cleverly executed drawing, representing our Operating Theatre in the year 1977, as seen by the prophetic "mind's eye" of the artist. Though the scene is familiar, the actors in it (and their actions) clearly show that despite the opposition of Convocation, and the unwearied hostility of the G. H. G., the natural superiority of woman over man will (100 years hence) have asserted itself most unmistakably —for here is depicted the operation of "Excision of the heart (male)" undertaken by a lady operator, and, apparently, giving rise to very little interest on the part of the lady spectators, if we may judge by their behaviour. In the clouds which fill the upper part of the picture, are seen the members of the present Surgical Staff—whether in apotheosis, or in the character of cherubim is not evident, since nothing but the head of each is visible, some, especially the Seniors and Consultants, beaming down good naturedly; others, with countenances evidently overcome by natural feelings of chagrin at the extraordinary alterations that have taken place in the once familiar arena. Another clever drawing entitled the "The Shadow of the Feast" well repaid a walk to the end of the ward. The green decorations also, as usual, were excellent.

LAZARUS, with its green festoons on each bed, and its prettily designed wreaths beneath the quaint old numbers, looked very warm and Christmas-like; the text worked in yellow immortelles on a green background had a pleasing effect; the doorways and cupboards also looked very cosy in their plain green margins.

SAMARITAN and PATIENCE, though usually left to the last, were well worthy of a visit, both being fully decked out in wreaths of green, and Christmas greeting, skilfully worked out in holly berries on a white ground.

We have looked in vain through the hospital for a certain scroll, of which we received information, where a blessing was invoked in red tape for "Economy," and "New System of Nursing"; we can only suppose that our informant was himself misinformed, or that the seasonable decoration is displayed in some part of the building to which neither Staff nor Students have access.

We have only to say that the Puddings were well up to the mark, and generally approved of by the Annual Committee, which consists of the Residents for the time being. CLINICAL and ADDISON were the best Medical puddings.

REMINISCENCES OF AN EXTERN.

Leaving our more comfortable quarters, we settle down in the aristocratic neighbourhood of Maze-Pond, and speculate on the honesty of our landlady, and the prevalence of bugs; we are disturbed by a knock at the door and the intimation that a card is waiting for us. We go out and find a dirty ragged Irishwoman, with a yet dirtier card, on which we can just decipher, through the dirt, the words Guy's Lying-in Charity. Quickly we get our hat and hurriedly we follow the woman as she half runs on before us, as if a life depended on her haste. Alas! she little knows what a tyro is following her, nor do *we* as yet recognize this fact. Have we not read "Playfair" and learned "Swayne's aphorisms" by heart? Through street after street she passes; each narrower and dirtier than the preceding, until suddenly she darts through a narrow passage into a court. It is our first acquaintance with "slum" life, and as such it quite dismays us. Small girls, with only a dirty gown on, stare us out of countenance; half naked boys are on all sides: knots of fierce looking women whisper audibly that "that's the doc*ter*," and proceed to comment on our age and appearance in a way hardly gratifying to our vanity. By the time we have reached the end of the court all our knowledge has vanished, and we hardly remember a word of Swayne, to say nothing of Playfair. We recollect, however, that we must appear "quite at home" in all situations, and we hope that

at least we are capable of doing this. But we little know what is before us. We enter to find a woman sitting on a bed in a filthy garret, half darkened by the rags which have been stuffed into the broken window panes. The one chair is occupied by a tall Irishwoman who is sipping gin, of which she invites us to partake. We proceed to ask the patient as to her former labours and last pregnancy, and with horror learn that she has already had twelve children. Of course the "pains" have for a time departed on our arrival, allowing her, in fluent terms, to expatiate on the merits of the last "young man" from the hospital. She describes to us the difficulties of labour in general and of her own in particular, while she wonders how a woman after having gone through one labour can ever be fool enough to allow the chance of a second. We perfectly agree with her, although, as we are trying to recall a little of our knowledge, we heartily wish she would be quiet. At last a "pain" puts an end to her talking, whilst we, with a sinking heart, proceed to make our first digital vaginal examination. How much we should like to ask her whether we are exploring her rectum or vagina. We feel sure that she would aid us in our search for the "os." for which we diligently seek until the cessation of the pain puts an end to our hopes. With a nervous voice we assure her that the labour will soon be over. She does not appear to believe us; and we, as we wash our hand, in vain attempt to decide what cavity we have been examinimg. The tall Irishwoman begins to cross-examine us as to how many labours we have attended, and we suspect that she knows that the externs change each month, and that this is the first of December. However, we put her off, and having waited half an hour we again examine, and with a flush of pride we diagnose vertex presenting, "os" as large as half a crown. After this we think we may retire for a few minutes to collect our thoughts, and we proceed downstairs. In a few minutes, however, we are called, and run upstairs to find the child in the bed, whilst the women are exclaiming that we are no good at all. The baby is soon released, and we are thinking that now it will soon be over, when our Irish friend remarks that "the brat's a small'un," and that "Moll will have twins, as she had the time afore." Certainly the birth of her offspring has not much affected her size, and so we propose to examine her, although we have quite forgotten what to look for. Playfair's descriptions have departed, Swayne has melted into thin air. It seems as if all our knowledge had suddenly filtered through the cribriform plate with which nature has so foolishly supplied us. Anyhow, we state our belief that twins are to be expected, and prepare to wait. Minute succeeds minute, quarter of an hour becomes an hour, still we wait. All of a sudden out comes something, is it the missing twin? No! it is only an enormous diseased placenta. Scorn is on all their faces, as we wash our hands and rush home to meditate on the *practical use* of book-work and on the ingratitude of womankind.

EXAMINATION NEWS.

SECOND M.B. EXAMINATION FOR HONOURS.

MEDICINE (morning).

1.—Describe the lesions, resulting from Syphilis, in the Liver, Lungs, Brain, and Vessels.

2.—Describe the symptoms of Disseminated Sclerosis of the Nerve-centre. State in what respects they differ from those of Paralysis Agitans and Locomotor ataxy.

(Afternoon.)

1.—Describe the characteristics and variations observed in the pyrexia of the following diseases:— Typhus, Typhoid, Acute Pneumonia, Tubercular meningitis, Sarlatina, Measles, Variola.

2.—Describe the complications of Pulmonary Phthisis in the adult.

OBSTETRIC MEDICINE (morning).

1.—What are the principal indications for the Induction of Premature Labour, and the best means of accomplishing it under the different conditions requiring it?

2.—What are the chief causes of Rupture of the Uterus? Describe its symptoms and management.

3.—Give a description of Placenta Prævia and of its appropriate treatment. State the grounds of your prognosis under the various aspects of that complication.

(Afternoon.)

1.—State what you know of the function of menstruation; and describe the changes occurring in connection with it in the uterus and ovaries.

2.—What are the various causes of amenorrhœa occurring as a symptom of disease? Describe the symptoms associated with Amenorrhœa in its various forms, and the treatment you would adopt.

3.—Describe the symptoms, diagnosis, and treatment of Inversion of the Uterus, (*a*) as it occurs during labour; (*b*) as it is met with when it has become chronic.

FORENSIC MEDICINE (morning).

1.—What is the condition of the Pupils in ordinary sleep, chloroform narcosis, apoplexy, alcoholic coma, poisoning by opium, carbolic acid, calabar bean, hyoscyamus, strychnia and aconite? How would you make a diagnosis, and what course would you pursue in the case of a patient found in the street in a state of insensibility?

2.—Describe the symptoms resulting from total Deprivation of Food, and the more prominent and characteristic signs of death from starvation. What circumstances require to be considered in forming an opinion as to starvation being the cause of death?

3.—What are the symptoms and post-mortem appearances of poisoning by Charcoal fumes?

4.—State in what forms of disease, and in what forms of poisoning, Muscu ar Tremors are a characteristic symptom, and specify the other features, bodily and mental, which you would expect to find in each particular case.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

DIPLOMA OF MEMBER.

EXAMINATION ON SURGICAL ANATOMY AND THE PRINCIPLES AND PRACTICE OF SURGERY, NOVEMBER 9TH, 1877.

1.—Describe the position and relations of the Prostate, and the effects produced by its enlargement.

2.—Enumerate in order the parts which would be divided in Amputation of the Thumb at the Carpo-Metacarpal articulation.

3.—What are the Pathological changes which occur in Whitlow? Describe the complications which may arise in severe cases.

4.—Describe the structure of a Varicose Vein; and the causes and consequences of that condition as affecting the lower limb.

5.—What are the diagnostic symptoms, and the treatment of Acute Glaucoma?

6.—What are the early symptoms of inflammation of the Hip-joint? Describe the appropriate treatment.

EHAMINATION ON THE PRINCIPLES AND PRACTICE OF MEDICINE, NOVEMBER 10TH.

1.—Describe the symptoms of, and the pathological conditions giving rise to, Hemiplegia, with the general principles of treatment in the different stages.

2.—Describe a case of acute Bronchitis in the adult, giving the causes, course, physical signs and treatment, with two different prescriptions written out in full,

3.—What are the different effects of opium, belladonna, hyoscyamus, cannabis indica, chloral, and stramonium? what are the chief indications and counter-indications for their employment?

Communications, &c., received from Dr. Goodhart, Mr. W. Rendle, Mr. Besle, Mr. Hartley, Mr. Mahomed, Mr. Collins, Mr. Sheppard, Dr. Sheen.

We acknowledge receipt of *Medical Press and Circular; Sanitary Record; Proceedings of Medical Society of County of Kings, U.S.*

In the *Practitioner* for November is a very useful article by Dr. Faber, "On the choice of the Sea Route, and the vessel best suited for therapeutical purposes, with practical hints regarding the outfit of an invalid, his accommodation and life on board," being the conclusion of a series of papers "On the influence of Sea Voyages on the Human Body and their value in the treatment of Consumption." This will be of great value to General Practitioners who wish to send their patients for a sea voyage. It gives excellent information on the Sea Routes and as to the best line of vessels; the advantages and disadvantages of steam and sailing vessels, with many useful hints as to the general management of the patients. We would recommend its careful perusal to all Guy's men.

TENTH EDITION.

MATERIA MEDICA EXAMINATIONS.

BRITISH PHARMACOPŒIA, 1867,

Further enlarged by additions to the B.P., &c.; and there is now included, in each case, a copy of "The Organic Materia Medica," by W. SOUTHALL, F.L.S.

The Original Collection of Specimens of the Organic Materia Medica of the British Pharmacopœia, for the use of

MEDICAL AND PHARMACEUTICAL STUDENTS.

These Collections comprise all that a Student requires to assist him in preparing for his Materia Medica Examination. Each Collection consists of about 150 carefully selected and characteristic specimens of the Roots, Barks, Flowers, Fruits, Leaves, Resins, Gums, &c., of the British Pharmacopœia, 1867. Each Specimen bears a label containing a description of the source from which the article is derived, its natural order, characters and tests, dose, and the names of the Pharmacopœia Preparations into the composition of which it enters. The Student is thus enabled, in the most effective manner, to study Materia Medica with the actual substance as well as the descriptive text before him.

The Price of the Collection, in a neat wooden box, 30s. net. (The Copyright of these Collections is Registered.)

OPINIONS OF THE PRESS.

Favourable opinions have been received from the Editors of the MEDICAL TIMES AND GAZETTE, BRITISH MEDICAL JOURNAL, PHARMACEUTICAL JOURNAL, and CHEMIST AND DRUGGIST.

We have received a number of unsolicited letters, expressing warm approval of these Collections. The following are extracts from some of them:—

From Professor C. B. C. Tichborne.

"40, Mary Street, Dublin, 24th November, 1875.

"Gentlemen,—I have examined the case of specimens, and consider them invaluable for educational purposes. They are evidently chosen with great care, *and are in every case typical specimens.*

"Believe me, Gentlemen, yours very truly,
"CHAS. B. C. TICHBORNE."

From Manchester, April 20, 1876.—"The specimens ought to be in the hands of every medical student and chemist."

From Glasgow, February 24, 1876.—"I am very much pleased with them."

From Cork, April 7, 1876.—"The specimens are most useful. Several of my fellow-students said they would send for them."

From London, May 7, 1876.—"Your excellent collection to hand, with many thanks for its repleteness."

Besides the "Students' Set," we supply larger Collections for the use of Professors at Universities, Lecturers, &c., as the following letters show:—

From Prof. Geo. F. Duffey, Lect. on Mat. Medica, Dublin.

"Messrs. Southall Bros. & Barclay. "Dublin, March 18th, 1876.

"Gentlemen,—I received the specimens on Thursday. I am very much pleased with the collection you have sent. It is extremely neatly and well put up, and presents a remarkably good appearance in the Museum. The specimens all seem equally good and characteristic; and I think, considering the liberal quantity of each specimen sent, and the care and trouble that have evidently been taken in selection and arrangement, that the price is reasonable.—Yours obediently,
"GEORGE F. DUFFEY."

The following note is from Dr. P. W. Latham, Professor of Medicine, Cambridge University:—

"Cambridge, February 25th, 1869.

"Gentlemen,—Enclosed I send you a cheque for the amount due from me, I am extremely well pleased with the collection of vegetable specimens with which you have provided me, and am very much obliged to you for the trouble you have taken. In my lectures on Materia Medica I have shown my class your 'Students' Collection,' and strongly recommend each member to purchase one. You have conferred a great boon on Medical Students, by placing within their reach such a collection at so reasonable a rate.—Yours obediently,
"P. W. LATHAM."

Dr. Muter, Director of the South London School of Pharmacy (New Kennington Institute), writes:—

"289, Kennington Road, S.E., London, 14th September, 1871.

"Dear Sirs,—I am last night in receipt of the large set of specimens sent by you as an addition to our Museum of Materia Medica. They are exceedingly good and characteristic, and give me the greatest satisfaction. I will always in future desire my students to possess themselves of your 'Students' Set' for home study.—Yours faithfully,
"JOHN MUTER, Ph.D., M.A., F.C.S., Director."

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Sent to any part of the United Kingdom on receipt of Post-office Order.

SOUTHALL BROS. & BARCLAY, Manufacturing Pharmaceutical Chemists,

BIRMINGHAM.

Clinical Lecture.

By DR. PAVY. *Saturday Jan. 12th.*

1st case.—Acute Rheumatism. C.S. æt. 19. Good family and personal history, never had rheumatism before. Present attack commenced 3 days ago, she was out in the wet the day before, and felt cold and shivering on going to bed, next morning woke up so stiff that she could not get out of bed, nearly all her joints were painful, but not red.

January 7th.—*On admission*, patient has pain in nearly all her joints, those of the right arm only being free. *Heart.*—There is some harshness about 1st sound at apex. T. 103.5 at 3 p.m. Ordered Emp. Lyttæ 3x4 Regioni Cordis, and Acidi Salicylici gr. xx in M. Amn Acetatis ℥j 2tis horis. Milk and Farinaceous food, 9 p.m. T., 101.4; P. 94. Bruit at apex.

8th.—T., 101.2; P., 96; E. T., 100.2; P., 100; R., 36.

9th.—T., 100; P., 120. Pain in right arm, perspires freely, hurried respiration, a to and fro sound at base like that which often precedes Pericarditis; roughness at apex.

10th.—E. T., 100.

11th.—T., 100; E. T., 99.5; P., 96; R., 33.

12th.—E. T., 99.4; P., 101; R., 28; prolonged first sound at apex and some roughness at base, no pain in any of the joints except right arm a little tender.

13th.—E. T., 99.6.

14th.—E. T., 99.9; R., 98.8; P., 78.

15th.—E. T., 98.6.

16th.—No pain in any of joints, T., 58.5.

17th.—T. normal, remained so ever since. Taking Salycin four times a day.

Remarks.—Diet in these cases is of the utmost importance, a stimulating diet often produces a relapse, and so we may fairly presume than an animal or stimulating diet will only augment the severity of the disease. The best diet is milk and farinaceous food, beef-tea is too stimulating, though we dont perceive it because we live on animal food, but accounts from good authorities show that in vegetarians, such foods as beef-tea, Liebig's extract, &c., produce increase of circulation, and decided increase of inflammation.

Reduction of temp. should be the great aim of treatment in acute rheumatism; when this is accomplished all the symptoms disappear. The best agent for this purpose is Salycin, or Salicylic Acid, and the above case affords a good example of its efficacy, and besides relieving the present attack, it must certainly affect the future condition of the heart disease, but this can only be proved some years hence when cardiac disease ought not to be so commonly met with as it is at present. The remedy from Dr. Pavy's experience ought to be continued till 12 or 14 days, or even more after the acute symptoms have passed off; if left off earlier a relapse may occur, and then is often more difficult to cure than a primary attack.

Case 2.—Acute Hydrocephalus, Tubercular Meningitis, S. T. æt 19. Nurse at Evelina Hospital.

Family Hist.—Father died of Congestion of Brain, one brother very much troubled with head, one died of Convulsion, and one sister of something very much like patient is suffering from at present.

Personal History.—Good.

Present Illness.—Was out for Christmas holiday, returned on the 28th complaining of head-ache and pain in back, and said she had not felt well for a week, having had head-ache and general feeling of weariness. On the day she returned she had several rigors. Since then she has complained much of pain in back and general restlessness, bowels have been very confined.

On Admission, January 7th.—Somewhat fretful, every half minute or so, gives a short sobbing sigh, does not seem able to rest easily and tosses her hands to and fro. Cannot bear the light and likes to be quiet. Head hot and cannot bear pressure on right side of scalp. Bad appetite ever since she has been ill, only taking about a pint of milk per diem. Breath highly offensive, tongue dirty white, bowels confined, abdomen tympanitic.

Heart and Chest normal.—Urine dark, loaded with urates S. G. 1034, passes about Oj per diem. T., 102.8; P., 160; R., 58; sick in evening. E. T., 99.2; P., 95. Quite sensible. Ordered milk diet. Lotio Spiritus to head. Pulv. Scam. c cal. gr. xv. statum M. Salina ℥j, 6 tis. horis.

January 8th.—Bowels opened. Constantly picking lips and ears. Slight Hyperæstheria on chest. Tâche Cerebale well marked. Small hard pulse, T., 100; E. T., 102.6.

9th.—Starts on slightest disturbance. Some erythematous spots about chest and abdomen. E. T., 102; P., 100; R., 28.

10th.—Very restless, hands continually moving. E. T., 101.8; P., 100; R., 29.

11th.—Abdomen slightly retracted at sides and flatter than normal. E. T., 100; P., 114; R., 24.

13th.—Bowels opened freely, constantly pressing hand to forehead, great pain in head.

Remarks.—There is a strong family history of brain disease in the case, the symptoms of which are typical of meningeal disease, and on that account they are well worth watching as the symtoms of meningitis are always much the same, whatever the cause. In the present instance it is supposed to be tubercular, because there is no other obvious source of inflammation, and the patient is a young subject. At present it is in the first stage, but in all probability the inflammation extends to the grey matter, and is not limited to the meninges. As it advances, the symptoms are modified, instead of having indication of exalted central action, there is depressed functional activity, no photophobia, &c., but anæsthesia, tendency to coma, paralysis, and often convulsions, ushering in death.

Case 3.—Chronic Hydrocephalus, C. Salgmos.

Family History.—Good, no history of drink, struma or syphilis.

Previous History.—Child was born quite naturally and easily, at birth there was nothing remarkable about its head. There is no history of worms, blow, or any cutaneous disease.

Present Disease.—When about 3 months old child became quieter and took less interest in its surrounding. Three weeks later mother noticed that its hat was too small to go on its head After this it frequently vomited, since the child has been very quiet, very susceptible to noise, but scarcely taking any notice of light; it has never had any fits or appearance of headache, but constantly drew up its legs, and seemed to have pain in its abdomen. Occasionally it screams on waking. Its appetite was good, bowels regular, and was not at all wasted till it was weaned 5 weeks ago, since then it has suffered from constipation, and the alvine evacuations are dark and offensive, its appetite is good, but it has wasted away a great deal.

On Admission.—Child is wasted, eyes protruded and in every way the type of a hyrdrocephalic child, head measures 24 inches in circumference, and 16 inches across vertex from ear to ear. Legs are rickety.

January 14th.—Tapped to day in usual position, 9½ ozs. of clear liquid fluid drawn off, pressure was kept up during whole time of operation, and afterwards maintained by means of strapping.

Remarks.—Usual seat of fluid is in the ventricles, but sometimes it breaks its way to the brain, the hemispheres then subsides and the fluid accumulates above this.

The disease may be compared to hydrocele, a local dropsy, possibly dependent on some chronic inflammation; but no medical agents seem to have any influence upon it; acting on bowels, skin or kidneys freely do not produce any beneficial result on the fluid in the brain, so tapping is the only chance of prolonging life in a case like this. Pressure must afterwards be applied in a case like this to maintain vessels in same state as before to prevent collapse.

CASE OF SCARLATINA.

UNDER THE CARE OF DR. MOXON.

M.C., æt. 13, admitted January 19th, into Bright Ward.

The girl, whose family history is good, was until the present illness in service. She has always enjoyed good health. On December 28th, 1877, she got her feet wet coming home late from a party,—it was a snowy night. Next day had a sore throat. Left her situation and went home on the 9th of January, eleven days after first taking cold; she now complained of pains in the knees, back and neck, with general pains all over. Since coming home her brother æt. 9 was taken ill (January 20th) with sickness and diarrhœa; sore throat next day and red rash generally. In the neighbourhood in which patient was in service scarlet-fever has been rife recently. The children in the house where she lived had scarlet fever a few days after she left. A week before her admission, ankles and knees swelled.

On admission, patient is a fairly nourished girl, cheeks flushed, skin warm and moist and covered with an acid perspiration, pupils large, wrists, ankles and knees swollen, red, and tender. A few raised red papules, about size of pins heads on her legs, which disappear on pressure. Tongue red, dry, cracked in centre, moist at edge and tip. Lips dry, and covered with brownish black sordes, and cracked bleeding fissures. Fauces and arch of palate dry, very red and inflamed. Tonsils enlarged and swollen-looking. Anorexia, thirst, dysphagia.

Liver dulness extends about ½ inch below thoracic margin, in nipple line. Splenic dulness increased. Tenderness in splenic region and right iliac fossa.

Abdomen tympanitic.

Chest expands well; tactile vibration, deminished at both bases; percussion note good; breathing puerile.

Cardiac impulse diffused; dulness slightly increased; roughened first sound at apex, soft systolic murmur at base. Pulse regular, large, strong, fairly compressible. Speech thick, talks through her nose.

Urine opaque, orange color; sp. gr. 1021, very acid; no albumen or sugar; deposit disappers on boiling.

January 19th. Bowels open four times. Morning,—Temperature, 103; Pulse 128. Evening,—Temperature, 100.2; Pulse, 112. R. Acidi Salicylici gr. xv. Sod. Bicarb. gr. xv. Aq. Menth. Pip. ʒj. 2 dis. horis. Milk diet. Tongue dry. No pain in joints, but great head ache.

21st. Rep. Mist. 6 tis. horis. Morning,—Temperature, 99.6; Pulse, 108. Evening,—Temperature, 101; Pulse, 100. Respiration, sighing and noisy; talks in her sleep. Bowels open several times; motions liquid, but not typhoid-looking.

22nd. Morning,—Temperature, 101.2; Pulse, 92. Evening,—Temperature, 99.0; Pulse, 92. Brown fur in centre of tongue. Loud systolic bruit heard at base of heart. Medicine to be discontinued.

23rd. Skin desqnamating from Abdomen and hauds. Albuminuria. Right knee very much swollen Morning,—Temperature, 99.0; Pulse, 86. Evening,—Temperature, 99.8; Pulse, 100. Mist. Pot. Chlor, ʒj. 4 tis. horis. Diarrhœa has ceased.

24th. Patient rubbed over with carbolic oil, in places that were desquamating. Precordial dulness increased still more. Systolic basic bruit more distinct. Morning,—Temperature, 99.4; Pulse, 88. Evening,—Temperature, 100.2; Pulse, 92. Patient rubbed again with Carbolic Oil as before.

25th. Patient washed with a very weak solution of

Carbolic Acid, over desquamating parts. Tongue moist at edges and lip, furred in centre. Tonsils almost meeting in middle line and very red. Fauces and arch of palate bright red. More sordes collecting about lips and teeth. Pulse soft and compressible. Right knee still swollen. Desquamation still going on. Urine, Acid, contains Albumen; sp. gr. 1019; no reaction with quaiacum. Murmur at base, Dr. Moxon thinks is hœmal. Morning,—Temperature, 99; Pulse, 80; Respiration, 24.

26th. At 7.40. a.m. a change came over the patient's appearance; the hue of her skin changed to a sickly sallow; the lips became livid, and literally covered with black sordes. Tongue covered with blackish fur. Cadaverous countenance. Conjunctival tinged a faint pale yellow. Dulness over whole of lower part of left side of chest in front, and at extreme base behind. Heart's impulse felt strongly on palpation; most distinctly in second intercostal space. Murmur at base is harsher; heard loudest in second interspace; absent below nipple. The respiration has become peculiar. She sighs deeply twice, then one or two shallower ones, gradually decreasing, until she stops completely, and after a pause of five or six seconds, repeats the process, the pulse not altering. Respirations are equal in time to the pause. Bowels open four or five times, liquid dark brownish motions. Temperature, 103; (12.25.) Pulse, 120. Urine sp. gr. 1014. Albumen present. Patient is quite conscious, answering questions rationally; but is drowsy. 3.45. p.m.—Temperature, 104; Pulse, 136. 8.40. p.m. Breathing lost its former character, but is getting stertorous. Temperature, 103.6; Pulse, 116. Diarrhœa. Motions black.

27th. Temperature, 97; (10.30. a.m.) Temperature, 96.2; Pulse, 103; Respiration, 32, (12.30.) Pulse very soft and compressible. Tongue dry: Pupils contracted. Urine black; becomes almost solid on boiling. No blood. No smell of Carbolic Acid, but this was found in the urine afterwards, by the bromine test applied both after dyalysis, and to a portion of the distillate after distillation. Patient sank and died at ten minutes-past one of clock in the afternoon.

Post Mortem.—Broncho-pneumonia at left base. Fatty degeneration in muscular fibres of heart. No valvular disease. No pericarditis and no endocarditis. Kidneys, chocolate colored, highly congested. Spleen enlarged. Peyers patches normal, solitary glands swollen.

POISONING BY IVY.

A short time ago I was hurriedly called to see an old man "in a fit." On arriving at the house I found the man in bed with the following symptoms:—

He had a somewhat bewildered appearance, seeming to be unconscious of what passed around him, eyes half-closed, pupils however normal, equal, and reacting to light. When spoken to he seemed to understand imperfectly, and his attempted replies to questions were a mere mumbling of words. The right lower limb when raised and let go fell down powerless, and seemed quite paralysed; there was some rigidity in right arm, though this also he never moved, whilst he did occasionally move about the limb on the left side. The face was not drawn to either side. The tongue was very red, and in fact looked raw. The pulse was over 100°, and rather weak. Respiration 26°. Temperature normal. Heart not hypertrophied, and arteries not abnormally thickened. I obtained some of the urine afterwards, and there was no albumen. There was no sickness.

I was told that he came home about 11 a.m., as was his wont, to have some lunch, and nothing was heard unusual; about 12 o'clock the landlady, who keeps a small shop, chanced to go to his room, and found him sitting in his chair looking "queer" and unable to speak. She called assistance, and he was got into the bed, it being noticed that his right side seemed powerless. She said he had once lost the use of his right side for a time some years ago. I could come to no other conclusion than that it was a case of right hemiplegia with partial aphasia. When I suggested his being removed to the hospital he manifested great objection, and so I left, after giving instructions that he should be kept quiet and be watched, and that no stimulants should be given.

The same evening, about 7·30 p.m., I was again hurriedly fetched, and now found him quite delirious, talkative, and excited; all symptoms of hemiplegia and aphasia had vanished; indeed it was as much as two people could do to hold him in bed. He spoke rapidly, in short sentences. He did not recognise those around him, except his daughter. He picked at the bedclothes, and seemed fond of playing with the buttons on my coat, but his hands trembled very much. He seemed very suspicious that something was going to be done to him and would not lie down in bed, say or do what we could.

I now quietly dismissed the idea of hemiplegia and aphasia and took up Delirium Tremens. Questioning, I found that he was a very abstemious man, and certainly was not known to have been drinking at all lately; it was ascertained that he was quite sober up to 11 a.m., and nothing having contained spirit had been found in his room. Nevertheless I couldn't see what else it could be. I ordered him a dose of Chloral Hydrate, and the following morning found him quite conscious and apparently well. He had gone to sleep about two hours after taking the Chloral, and awoke next morning feeling all right. His tongue and throat were very red, but not painful. He stated that he had come home on the morning previous, had some bread and butter and half-a-pint of beer, and nothing

else; he denied having tasted spirits of any kind; he did not know how he came to lose himself, but remembered nothing after attempting to rise from his chair to walk across the room until the following morning. I confess I was quite puzzled with such a speedy recovery, and indeed with the whole case. Just before leaving him he asked me if "Ground Ivy" were poisonous; saying I did not think so, I requested why he asked, and he then told me that he had bought a pennyworth from a herbalist, made a decotion of it, and taken it in the beer, as he was told it was a good thing for Rheumatics. I asked him to buy me a pennyworth from the same herbalist, as he had none left. He got about in a short time, and obtained some "Ground Ivy," just like that which he had taken. I submitted this to Dr. Stevenson, who at once saw that they were the leaves of the common Ivy, and not Ground Ivy.

He has kindly permitted me to publish the following account:—

Common Ivy.—*Fam. Hederaceæ. Hedéra Hélix L.*

The plant yields (1) a gum-resin (sphenharz Germ.) of an orange colour, which acts as a diaphoretic and emmenagogue; (2) an alkaloid, hederine, the existence of which is doubtful, though described by Vandannine and Chevallier (J. Chem-Med. xxv.) as existing in the seeds. (3). In the seeds heaeric acid (C_{15} H_{26} O_6 H_2o?). (4.) In the seeds hederatannic acid.

The two last were discovered hy Posselt in 1849.

In 1876 Davies and Hutchinson (Trans. of British Pharm.) confirmed presence of hederic acid, and were unable to find hederine. They found that the new (?) body found by Hartsen (Archiv. der Pharm., April, 1875) is probably hederic acid (obtained from Ivy leaves).

It is curious that both in France and England ground Ivy (a labiate) and very like the dead-nettle has a name indicating its likeness to Ivy. The French for Ivy is "*lierre*," for ground Ivy "*lierre terrestre*." The Latin name for Ivy is "*Nesseta Glechóma*," and was formerly "*Glechóma hederacea*," a name indicating its likeness to Ivy. The leaves of Ivy are coriaceous ovate or cordate and five lobed, lobes angular; those of ground Ivy, cordate, reniform, *crenate*. Ivy leaves are shiny, ground Ivy *downy*. Dorvault speaks of the berries of Ivy as used for syphilis and ringworm; the leaves as used for dressing cauteries. He says that an infusion (10:1000) of the leaves of ground Ivy is used as a pectoral.

Planchon speaks of Ivy as formerly used for dressing cauteries, and says that a decotion is used for vermin on the head, and that it enters into the "tisane" of Feltz, according to Boumie's formula; but Pirvault gives a formula for this diet-drink of sarsaparilla, isinglass, and antimony sulphide, in water.

I continued to attend this patient for a day or two, during which he kept at home, although not feeling any bad effects except a little weakness. He then went to his work again, and I have often seen him since looking quite hale for a man of his years. He told me quite recently that he had been using an infusion of this same Ivy, got from the same herbalist, under the name of Ground Ivy, as a lotion or linament for his rheumatic joints, and that it did them good.

If common Ivy be at all poisonous, and this case would at least shew that it is very deleterious, it certainly ought not to be sold for ground Ivy, which is a popular remedy for bronchitis, rheumatism, &c., though not so commonly used now as formerly.

P. HORROCKS, M.B.

THE PRESERVATION OF HEALTH.

In this present nineteenth century, with its scientific discoveries, and its facilities for the spread of knowledge, we are apt to look back upon the doctors of two or three centuries ago as mere empiricists and quacks. Ignorant they certainly were on many essential points, and when it became necessary to conceal that ignorance from the public view they resorted to expedients that appear to us *ridiculous*, because they are incomprehensible. But this is a fault too widely spread to be deserving of blame in any particular set of men; and we must wait until we are absolutely without sin ourselves before we begin to cast stones at our predecessors. The object of this article is to show that, in spite of the disadvantages under which they laboured, they were quite capable of giving much sound advice; and such as might now be followed by many people with advantage to themselves, as well as to others. For this purpose we must ask the reader to forget for a while his present surroundings, and to imagine that he is receiving instructions from his "Doctor of Physicke" in the glorious time between the years 1564 and 1616, as to the mode of life that will best tend to the preservation of health.

First of all, when you arise in the morning, stretch yourself, "for by this meanes the animal spirits are drawne to the outward members, and the braine is made *subtill*, and the body strengthened." Then rub your body all over either with the hands, or a warm cloth. In the summer you should take a bath; but in the winter "sit somewhat by the fire, not made with turfe or stinking coate, but with oake or other wood that burneth cleare." When you have done this, put on your clothes, comb your hair some forty times with an ivory comb; "for nothing recreateth the memorie more." Wash your face and clean your teeth, and be very careful about washing your eyes, immerging them open in the water. Students have always done this, and have "preserved their eyesight free from all passions and bloodsheds, and sharpened their memories *marvaylously*."

As to the material for your clothes, Hartskins are much to be recommended, "for the Hart is a creature of long life, and resisteth poyson and serpents." In time of pestilence you must never wear silk, "because it doth easily admit and receive the contagious ayre, and doth retain it long." At other times you may wear it.

When you are dressed, "walke in your gardyn or parke a thousand pase or two, then serve God with some prayers, surrenderynge thankes to hym for hys manifold goodnes," and then get your breakfast, and go to your work like an honest man.

You should never eat more than three meals a day, breakfast, dinner, and supper. There should be four hours between breakfast and dinner, and seven between dinner and supper. No meal should consist of more than two or three dishes, and of these the lighter should come first, "to make the belly

soluble. Drinke not above four times, and that moderately at each meale, least the belly-god hale you at length captive into his prison-house of gourmandise, where you shall be afflicted with as many diseases as you have devoured dishes of sundry sorts."

Abstain altogether from drinking between meals, "unless necessitie or custome doe require the same; *notwithstanding the same custome being so vitious, must be by little and little changed.*"

Always clean your teeth after a meal; and don't begin to work too soon. "Pass an houre or two in pleasant talkes, or walke yee gently, and soberly." Be careful not to sit up late at night; but if *honest business* compel you to do so, be sure you take it out next morning by lying later; "that your sleepe may well recompence your former watchings." Avoid going to bed immediately after supper; and before you do so rub your body well as you did in the morning. In the winter you should undress by a fire. Take off your clothes, and with the lay aside "all your cogitations, whether they be public or private, for when all your members be free from all cares, you shall then sleep the quieter." Pray to God "to defend you from all perils and subtelties of wicked fiends;" and "let your night cappe have a hole in the top, through which the vapour may goe out." Lastly, adopt the following as a general principle as regards sleep. "Whole men of what age or complexion soever the be of, shulde take theyr naturall rest and sleye in the nyght; and to eschewe merydyall sleep. But and nede shall compell a man to slepe after his mete; let hym make a pause, and then let him *stand and lene and slepe agaynst a cupborde, or els let hym sytte upryght in a chayre and slepe.* Slepynge after a full stomacke doth ingendre dyvers infyrmyties, it doth hurt the splene, it relaxeth the synews, it doth ingendre the dropses and the gowte, and doth make a man look myll colorec!"

Is it not a duty to make known the horrible results likely to arise from this too prevalent habit?

PROFESSOR CHARCOT'S CLINIQUE.

The *La Salpêtrière* is one of the most important hospitals in Paris. It is situated on the south side of the river Seine, not far from the Pont d' Austerlitz and within a few minutes walk from the Jardin des Plantes. It consists of several long rows of buildings, separated by wide interspices. It covers a very large area of ground. Some idea of its magnitude may be derived from the fact of its containing 4000 beds. It is devoted to the diseases and infirmities of old women. One house being for lunatics.

In the centre is the chapel with a large dome, which can be seen from a long distance. This hospital is renowned as the scene of the labours of Pinel, Esquirol, Cruveilhier and others whose names are well known in the scientific world. There Professor Charcot has been giving lectures for the last 13 years, many of which are now very popular, the Sydenham Society having had his work on Nervous Diseases translated into English. Dr. Charcot has a large number of beds set apart for his special studies. He visits the wards daily at 9.30. a.m. staying as a rule about an hour and a half. He lectures once a week on Sunday mornings at 10 a.m., the lecture lasting nearly 2 hours.

The wards are rather long, but not lofty enough, and the beds are too near one another; hence although everything is kept very clean, and ventilation is obtained as much as is consistent with comfort and warmth, yet on entering a ward from the fresh air outside it at once strikes our olfactory sense, as being anything but sweet. The patients however look very clean and comfortable, and everywhere one sees some display, however little, of art.

The French are a more artistic people than the English. Women are in all countries more artistic and neat than the men. Ergo, Frenchwomen must be artistic.

Over the end of each bed is a paper like our bed letters, with the name of the physician, patient, age, occupation, disease, &c., &c. In what is called the Epileptic Department one enters first a small room in which every morning are congregated 5 or 6 girls whose ages vary from 18 to 25 or more. Each of these girls are the subjects of hysteria and either have now or had formerly total hemianaesthesia. They sit knitting or sewing, and are very well behaved though from the ready silly giggles in which they from time to indulge, one has no difficulty in diagnosing hysteria. They have all in turn to take medicine in the presence of Dr. Charcot and his assistants, and by the wry faces which are pulled one would judge the physic to be nasty if not useful.

Dr. Charcot who is extremely kind to foreigners, many of whom visit him, was good enough to shew us during a recent visit the action of metals on the hemianaesthesia. And here let us remark that it is not exactly hemianaesthesia but hemianalgesia, because they can feel substances well enough, they can feel their knitting needle or sewing needle, but a pin may be passed through the skin deeply without the least pain. We were shewn a series of bracelets, consisting of round flat discs of metal strung on tape. The discs were rather smaller than an English florin and were made of different metals, gold, silver, copper, zinc, &c. They were made so that they could be easily slipped off the tape if required so that different combinations of the metals could be made. Gold acts best with some patients, silver with others, &c. It is found we believe that gold is more generally effective than any other. Instead of using these made bracelets, Dr. Charcot on this occasion took two gold coins (20 franc pieces) placed them flat against the arm of one of the girls about 2 inches apart and tied them on with tape. He then passed a pin through the web of this girl's fingers, another through a thick fold of her pinched up skin, and a third through her scalp right to her cranium without the slightest manifestation of feeling on the part of the patient. On taking them out one of the punctures bled which is contrary to what has been stated, viz. that punctures on the anæsthetic side do not bleed. In about 10 minutes the girl begun to feel the prick of a pin near to the coins but not at a distance. The sensation to pain spread however up and down the arm from the region of the coins until she had perfect sensation in her hand and shoulder. After another interval of 8 or 10 minutes the coins not having been distributed in the least there was again perfect hemianaesthesia. Dr. Charcot explained this by saying that sensation seemed to return in a wave like manner gaining an acme and then ebbing away, which process would be repeated again and again. He also said that hemianaesthesia was not a thing complained of by hysterical patients, but must be sought for by the physician, and that where it did not exist one could often produce it in hysterical girls by placing around the arm a bracelet of metals as described above, this being in fact a method of diagnosing hysteria.

(To be continued.)

On Duty for February:—House Physicians, W. P. Reynolds and C. W. Lacey. Junior House Physician, P. Horrocks. House Surgeons, A. G. Barrs and J. T. Gardner. Junior House Surgeon, W. C. James. Obstetric Residents, J. C. Uhthoff and G. Mackern. Dressers:—February 6th, Mr. Giles (Mr. Durham). February 13th, Mr. Keep (Mr. Howse). February 20th, Mr. Hearnden (Mr. Foster). February 27th, Mr. Granger (Mr. Bryant).

GUY'S HOSPITAL GAZETTE,

FEBRUARY, 1878.

GUY'S now has two House-Surgeons, and one Junior House-Surgeon; the appointment of the latter is new, dating only from the commencement of this year. His duties are to see the out-patients four days a week, when the Assistant-Surgeons sit, and to assist the House-Surgeons on Tuesday or Friday, either by administering chloroform, or by attending to the Surgery. At the Surgical out-patient department several reforms have lately been carried out. Not more than 50 new patients are to be seen on each day, of these, 20 are sent to the Assistant-Surgeon by the Junior House-Surgeon, the remainder being seen by himself, and for 20 of whom he has letters lasting two weeks.

The Assistant-Surgeons' Dressers see no patients on their own responsibility, but still perform the minor operations. Through these alterations, several patients are unable to be seen on some days, on others there is not a sufficient number to use up all the cards and letters.

The Office of House-Surgeon lasts for 6 months; the first 2 he spends amongst the out-patients, the second in the Surgery, and the third 2 months in the Wards.

By the new regulations, the number of out-patients is lessened. The Junior House-Physician sees 20 new patients 3 times a week. There are no doubt advantages both to patient and doctor, in thus curtailing the number of letters to be given out; but we fail to see any benefit to any one in making the out-patient letters so small in size, and to last only 2 weeks. In the first place it is often necessary to change the medicine the second week, and then one finds some difficulty in writing a second prescription without crowding it in at the bottom of the paper. Again in the majority of cases, especially on the medical side, a fortnight's medicine is a complete farce. We are told to put "R" on the corner of the letter when the fortnight has expired, if we wish the patient to be seen again; the chances are that the patient fails next time in obtaining a new letter, comes in without, the medicine is repeated on a piece of blue paper, the whole thing having to be written out again, wasting one's valuable time, life being very short. If one in the hurry and bother of out-patient practice should chance to omit putting "R" on a letter which has already been used for the long period of 2 weeks, it is retained by the Dispenser, and the following week, the patient, with or without a new letter turns up, and the whole of one's work has to be gone over again; for on that letter which the Dispenser has of course consigned to oblivion and which could scarcely be again discovered for love or money, were written the patient's name, age, married or single, number of children if any, symptoms complained of and duration of complaint and the physical signs observed by the Junior House-Physician or Surgeon as the case may be, the diagnosis and treatment. It is impossible to remember every patient who comes, and much less to remember all the information on that letter, which, at the early age of 2 weeks, met with an untimely fate. Indeed the patient has to have his or her case gone through entirely again, just in the same way as a new one. The chances are greatly in favour of a different medicine being prescribed, the patient returns the following week, saying, that the first medicine which she remembers had an odour of peppermint or camphor water, did her much more good than the last one. O what faith a 3 hours struggle inspires in a bottle of physic! But though we may order a menstruum of aq. menth. pip. or aq. camph. to please the fancy of the patient they are sure to say it doesn't taste quite like the first. We think it would be a decided improvement for "letters" to be made their former size, which was the same as those of the Assistant-Physicians or Surgeons, and that they should be available for at least 6 weeks. In a future number we may refer to certain abuses of the out-patient department due partly perhaps to present arrangements, but chiefly to a conscience-less public.

At this time of the year the Presidents of the Physical Society have the laborious and thankless task of collecting the subscriptions for the Gazette.

In order to keep the Journal afloat it is absolutely necessary that subscriptions should be forthcoming. The Presidents

give a large part of their time, which, to senior men is very valuable, in editing and bringing out the Gazette, and it does not seem fair to them that besides this they should have the task of hunting up every subscriber. It would lighten their labour very much if Guy's men would come forward with their subscriptions without being asked for them.

It should be in the heart of every Guy's man to try his best to keep up the *prestige* of this Journal and make it as valuable as possible. Clinical and Practical teaching have always been looked upon at Guy's as of primary importance, and the clinical record of cases, which serves both for study and reference, are a part of this teaching. It would help very much if those students who are now working in the wards would send up notes of all interesting and instructive cases to us for publication.

Physical Society.

Meeting January 12th, 1878, Mr. Horrocks in the chair, Mr. G. H. Russell read a paper on "Intestinal Obstruction."

The Paper was founded on the fatal cases of Intestinal Obstruction as recorded in the P.M. Reports of the last 22 years; the first 15 years having been collected in a Paper of Dr. Hilton Fagge's (Guy's Reports, 1869): the other 7 years is an appendix to the Paper.

By Int. Obstruction is meant constipation caused by a mechanical obstruction to the onward flow of the fæces. With the constipation are often associated sickness, abdominal tumour, visible peristalsis, collapse, suppression of urine.

About 6 people a year die in the hospital of intestinal obstruction, which is about 1.45 p.c. of all the p.m.'s (1869 to 1876, 3400 p.m.'s., 52 cases of int. Obst.)

Cases of Int. Obst. are divided into five groups—Impaction, Stricture, Compression (Contraction, Volulus), Strangulation and Intussusception.

IMPACTION.

Int. Obst. may be caused by the impaction in some part of the intestinal tube of (a) a gall stone (b) some indigestible material (c) of scybala.

A.—Impaction of a gall stone very rarely occurs. There is no fatal case on record at Guy's. It is usually found in women of advanced years. It is as a rule rapidly fatal: but the stone may be passed per anum and the patient recover. It is rarely diagnosed. There is no effective treatment.

B.—There is only one case on record of margestible matter causing fatal obstruction, that of an idiot boy who swallowed a quantity of cocoa nut fibres.

C.—Scybala are the most frequent cause of non-fatal obstruction. It is usual to say that they never cause *fatal* obstruction. Yet they sometimes appear to do so. There are three cases on record at Guy's.

STRICTURE.

Simple, Syphilitic, Cancerous. During the last eight years, there have been 27 fatal cases, viz., 9 Simple, 2 Syphilitic, 16 Cancerous.

Simple Strictures are congenital or caused by the contraction of the scar of an Ulcer, either Tubercular, or Dysenteric, or of Intussusception or Simple.

Syphilitic Strictures are very common: fatal cases are rare, and are fatal in consequence of rigorous treatment. They are always in the Rectum near the Anus. They occur almost solely in women: they are often complicated with Recto-Vaginal-Fistula.

Cancerous Strictures are common in all parts of the Large Intestine: but are never found in the small Intestine alone. There is usually only one Cancerous Stricture, but in 3 out of 34 fatal cases there was a second. Cancerous Strictures are often complicated with Fistula, &c.; the Cancer is never secondary: It very rarely invades the Intestine from the glands, mesentery, &c.

Clinical History: Syphilitic Stricture occurs in young women, and have a long (3, 4, 5 years) fluctuating (sometimes better, sometimes worse), history. Cancerous Strictures occur in people advanced in years: the history is never longer than two years: they advance steadily and progressively to a fatal termination.

COMPRESSION.

Under this head come Contractions and Volvuli.

Contraction of the calibre of the bowel is caused by some external pressure, by matting together of the intestines, by adhesions to other parts, by the contraction of a chronically inflamed mesentery, &c.

They resemble Strictures of the large Intestine in being Chronic, and in the absence of severe symptoms, Volvuli are cords of small intestine twisted on themselves. They are sometimes found on the p.m. table associated with contractions. Clinically no two cases of Volvuli resemble one another, so that the Volvuli belong to the "undiagnosible residuum" of Int. Obst. cases.

INT. STRANGULATION.

Is caused by a loop of intestine getting beneath a band or a hole in the omentum, &c.

Clinically they exactly resemble Strangulated Herniæ, except that no external Herniæ can be found. They are almost invariably fatal.

INTUSSUSCEPTION.

Occurs almost always in children. You may have Jejunal or Rectal, but the usual forms are Ileal and Ileo-colic.

In Ileo-colic Intussusception you get pain, sickness, the passage of blood per anum, and a Tumonr which alters its shape when manipulated.

In Ileal you get the same symptoms, but they occur in older patients, are more urgent and more rapidly fatal, and as a rule you cannot feel a Tumour.

DIAGNOSIS & TREATMENT.

You are apt to confound Int. Obstruction with Cæcitis, Pericæcitis, Peritonitis, and Ulceration of the Cæcal Appendix, unless some characteristic symptoms such as fæcal vomiting or visible Peritalsis be present. But this does not matter much as in the absence of sure guide in diagnosis you treat the case in the same way, viz. Opium, Rest, Liquid Food, &c.

Even if you are quite sure that the case is one of Int. Obstruction, you go no further in treatment without physical signs. For all *operative* influence should depend not on symptoms, which may vary, but on physical signs.

Thus—(1) A Stricture felt per rectum. L. Colotomy. (2) A Tumour felt in line of colon, R. Colotomy (or ditto) (3) Visible peristalsis and rolling of permanently distended coil of small Int. Nèlaton's Operation. (4) A Hernia and Symptoms of Strangulation, the Hernia operation, and then its extension.

At the Meeting, January 26th, Mr. G. Mackern in the Chair, Mr. Berry read a Paper on "Calculus Vesicœ, its varieties and treatment," of which the following is an abstract.

After referring to the composition of, and chemical characteristics of the three most common forms of stone (uric, acid, oxalate of lime and the triple phosphate), the paper proceeded to run over the different symptoms of stone; (such as pain, blood or gravel in the urine, &c.), and to discuss their comparative value or significance. It was not enough simply to diagnose the presence of a calculus, but was now necessary to determine if possible, the composition, size and number. We can learn a good deal from the character of the urine and the history, but it is often very difficult to decide whether we have to do with a uric acid or oxalic calculus. In sounding not only should the stone be felt, but rung also; as mistakes have frequently been made (even by skilful surgeons) from some point of bone against which the sound infringes, giving the false impression of the presence of a calculus. In sounding the old-fashioned instruments carved like a catheter and with flat handles should be discarded, and a sound with a cylinduial handle, and a short beak like that of a lithotrite should be used. The cylindrical handle allows it to roll easily between the finger and thumb, while the shortness of the beak permits of its being turned with facility to either side in the bladder. The question of the possiblity of the solution of the stone by internal remedies was then considered. Some of the many remedies of our ancestors were mentioned; it was pointed out that they all contained alkalics; and reference was made to the case of Horace Walpole who obtained such relief from the use of solvent remedies that he believed himself cured, and in whose bladder after death three small calculi were found.

The investigations of Dr. Roberts were noted. As a result of his experiments he comes to the conclusion that carbonate of potash is the best solvent for urine acid, (far better than carbonate of lithia), that a solution of 40-60 grains to the pint was most efficacious, and that by repeated doses of the acetate or citrate he can keep the urine sufficiently alkaline to correspond with such a solution. That the alkalescence being due to carbonate of potash and not to ammonia, had no tendency to cause the decomposition of urine or decomposition of triple phosphates, and that the acetate and citrate had no injurious effect on the digestive organs.

The rest of the Paper referred to the surgical treatment for stone, and the comparative merits of the two operations, lithotomy and lithotrity. Lithotomy was, in a rude and primitive fashion, practised in the time of Hippocrates, and advanced by slow degrees till the 17th century, when Cheselden perfected the lateral operation. Lithotrity is yet in its infancy, the first attempt to break up the stone into fragments, having been made by Civile, of Paris, in 1824. Great improvements have been made both in the shape of the blades and in the mechanism by which the force is applied; many of the objections that are given even in our newest text-books are now falling to the ground, thanks to the rapid advance of the operation. Cœteris paribus lithotrity is preferable to lithotomy, there being no need for any wound or break of surface; but if the stone be very large, or very hard, or if the bladder be irritable, the urethra narrow (as in children), or finally if the surgeon be not a skilful lithotritist, and it is an operation in which skill can only be acquired by (constant practice), lithotomy is to be preferred. At the same time many conditions which were thought to contraindicate lithotrity, such as hypertrophied prostate, or somewhat irritable bladder, are now known not to do so in consequence of the improvements made of late years in the instruments used.

MEDICAL CASES IN THE HOSPITAL.

CLINICAL WARDS.

No. 1. Admitted January 8th with sudden attack of abdominal pain and constipation, with frequent attacks of vomiting. He gave a history of similar illness previously. No cause could be discovered for the intestinal obstruction—Was treated with three grains of opium daily. Seven days after admission the bowels were relieved, and the patient appeared generally better. On Jan. 21st, there was sudden recurrence of pain in left side and back and the vomiting returned, these symptoms have subsided and the patient is still kept under influeuce of opium.

Nos. 4 and 14. Two cases of diabetes which are being treated with restricted diet, consisting of dressed meat, 12ozs. 3 eggs, butter, 2ozs. green vegetables, gluten, bran and almond buscuits, 8ozs. brandy, 4ozs. beef tea,

2 pints, soda water. The result has been satisfactory in both cases, as the following table will show.

(4) Jan. 9th, pts. 11 ozs. 8 of urine in 24 hrs. Sp. Gr. 1040 grs. of sugar to the oz. 43.35.

(14) Jan. 9th, pts. 7 ozs. 3 ; Sp, Gr. 1040, grs. of sugar to the oz., 50.

(4) Jan. 25th pts. 4 ozs. 0 Sp. Gr, 1035, grs. of sugar to the oz., 36.

(14) Jan. 26th pts. 3 ozs. 3 Sp. Gr. 1032, grains of sugar to the oz., 26.65.

No. 11. Patient at 11, has been the subject of hip disease during the last 5 years. His present illness began early in January, and at first was diagnosed as typhoid fever, and the course of the illness since admission justifies it in some respects, as the daily rise and fall of temperature, diarrhœa, etc. The spleen is enlarged and the urine is highly albuminous, the mind remains clear and there is no great prostration, eyes are bright and clear, the cheeks flushed—It is now considered to be a case of lardaceous disease.

No. 17. Woman at 53, the subject of malignant disease of the liver. The viscus is distinctly to be felt extending below the line of the umbilicus and is tender when pressed, especially at a spot on its right side, 4 in. from umbilicus. It is distinctly nodular although partly covered by a layer of peritoneal serous fluid. There is marked cachexia and constant wearing pain in the right side. This case is a good one for diagnosis.

No. 21. The patient (æt. 30) is the subject of albuminauria, probably from granular kidneys. The first symptom of disease was a fit of unconsciousness, lasting 24 hours on recovering from which, the patient found her eyesight affected. Retinal hæmorrhages were discovered and were followed by frontal headache. On admission albumin was found in the urine to about half, the average quantity of urine passed exceeded the normal and the Sp. Gr. was never above 1010. Some blood discs and epitheluim were found by the microscope. A systolic bruit has been occasionally audible at the base, but this is not constant. Pulse harder than normal. No enlargement of the heart.

No. 22. Presents a typical case of gastic ulcer.

No. 24. Admitted on January 7th, with intense headache and photophobia, sickness and utter want of appetite, having been ill for a fortnight previously with similar symptoms, accompanied by a rose rash all over the body, and some sore throat with constipation. The case was diagnosed as one of tubercular meringitis. Whilst in the hospital the previous symptoms have been exaggerated, she has been sometimes delirous at night but the mind has usually been clear, the characteristci moaning, sighing, picking at the bedclothes, etc., have been well marked. The temperature has generally ranged between 99 and 103.4, usually higher at night. She is now progressing favourably.

No. 32. Chronic Hydrocephelus in an infant aged 10 months. .The cranial bones are widely separated and fluctuation is everywhere most distinct, the child is blind, but all other functions normal. The head has twice been tapped to the extent of about half a pint of clear cerebro-spinal fluid.

No. 19 is a case of Diptheritic Paralysis, chiefly affecting the lower limbs and the ocular and laryngeal muscles. The paralysis followed rapidly on recovery from the disease and has since that time (3 months) gradually become less marked. Sensation is everywhere good and the motor power has partially returned in the legs, but latterly frequent vomiting has occurred and the speech has become more affected.

Lazarus 4. Suppuration about thigh following typhoid. A quantity of pus has been evacuated from a large abscess sac. There is much fluid in the knee joint, probably remipurulent.

Lazarus 7. Rupture of urethra in a boy age eight. Extravasation Perineal section has been performed.

Lazarus 8. Excessive renile enlargement of prostate with retention and acute cystitis.

Lazarus 9. Lumbar abscess. No evidence of spinal disease. History of a blow. Probably in the sheath of the erector spinal.

Lazarus 10. Subacute synovitis. Treated by blisters, rest and iodide of potassium.

Lazarus 17. Extensive burn and contraction of cicatrix. Has been treated by division and grafting. The mode of applying extension may be well seen here.

Lazarus 19. A case of supposed fractured base. Some paralysis on admission. This has now disappeared. Is recovering.

Lazarus 20. Necrosis of ribs. Patient is phthisical. A discharging sinus through which bone may be felt is daily washed out with diluted phosphoric acid.

Lazarus 21. Lymphadenoma. Boy age nine. Twice treated by excision of a number of large cervical glands.

Martha 3. A fairly typhical case of inflammatory glandular enlargement. May be usefully compared with the last case.

Martha 4. Subacute synovitis of knee. A well marked case giving all the characteristic appearances. The effusion is slowly disappearing.

Martha 6. A good example of spinal caries. Marked angular curvature and large lumbar and proas abscesses. All the diagnostic points are here well marked. The child will be put up in a Sayre, the abscess being previously opened. This case may be compared with 9 Lazarus. (Lumbar abscess unconnected with spine.)

Martha, cot 33. Rachitis. Much curvation of both tibial. Osteotomy will be performed.

Martha 21. Pulpy disease of knee. Should be compared with knee joint cases in the two Wards. Will be treated by free incisions.

THE ART OF PRESCRIBING.

In a recent number of the Gazette it is mentioned as a fact that candidates "for the second M.B. Lond. are often incompetent to write an ordinary prescription, and also that students value every chance which they get of prescribing for a disease, and that the amount of prescribing done by the dress rs and especially the clinicals give them a general idea of most of the best preparations in a practical way which they never forget." The first and second statements are very probably correct, but I am not quite so sure of the truth of the third. To prescribe for a disease is a certain method of learning the art of prescribing, but there must be one great essential attached to it, the prescription must be corrected by some competent authority, without this precaution unperceived errors are perpetuated. The acquisition of an art requires generally a certain amount of exercise, but success could scarcely be obtained without the correction of the errors inherent in the preliminary practice. I am as a

Pharmacist and a teacher of Pharmacy, able to understand the difficulties which lie in the way of a medical student acquiring the art of prescribing. It appears to me that although there is a provision made for the systematic teaching of Anatomy, Physiology, &c. there is none whatever for that of prescribing. The student appears to be left entirely to his own resources, he is compelled to start without a compass on a voyage of discovery on the combination of medicines. I am of opinion that a good prescriber should possess the following qualifications:

1st.—A thorough knowledge of Materia Medica and Therapeutics.

2nd.—A knowledge of Chemistry and especially a practical knowledge of Testing.

3rd.—Practical Pharmacy.

I am afraid that Materia Medica, Chemistry, and Practical Pharmacy are not appreciated as they deserve to be, but they are really of great importance. The Pharmacopœia should be as thoroughly mastered as Anatomy. The names of the preparations, strength, and doses as perfectly as the alphabet. It is perhaps allowable in the prescription of a practioner of thirty years standing to have the terms. Emp: Lyttœ, Sp. Ammon. Comp., Sp. Ether Sulph. Co: but they are unsuited for the College of Physicians or the London University Examinations. Accuracy in small details frequently indicates carefulness in other matters, a student who attends to minutiæ in his prescriptions most probably attends to diagnosis and treatment.

Unfortunately for Materia Medica and its sister Chemistry, these two subjects are taught in the first year when the mind of the student has not been sufficiently cultivated to grasp the importance of the facts which come from the lecturer. Afterwards other subjects are taken up and poor Materia Medica and Chemistry I fear in many cases are nearly forgotten. A certain amount of rubbing up takes place before examination, but this is frequently very superficial. Chemistry is an essentially necessary qualification for the prescription writer. From the prescriptions which are received at the Dispensary, and to which criticism may be honestly applied, I think the greater number indicate a weakness in Chemistry. A prescription the result of a diagnosis which indicates a chalybeate with a stimulant is not chemically written thus, ℞. Tinct. Ferri Perchlor ℥xx. Sp. Ammon. Arom ʒp. Ex. Aq. ℥j. t. d. s., nor an alkaline remedy with a slight aperient thus ℞. Liq: Potass ℥x. Mag. Sulph. gr. xx. Quit. Gentian: Co. ad. ℥j. t. d. s. neither would the following be a good form for a lotion, which had the intention of being both Deodorising and Anodyne. Lot. Pot. Permang., Lot. Opii. aa. p. ag. Practical Pharmacy should consist of something more than the signing of a schedule. The mind of the prescriber should be stored with facts concerning drugs and pharmacopœcial preparations acquired by actual practice. It ought not to be a matter of theory how Turpentine can be best made into a mixture or whether Mica Panis is a good excipient for a pill. My experience tells me that Practical Pharmacy is very rarely well learnt by students, and as a consequence their prescriptions bear traces of the want of this knowledge. I have stated that the art of prescribing is not taught systematically, that it is entirely left to be picked up, I am not surprised "that students value every chance which they get for prescribing for a disease," but at the same time I think it would be beneficial to the student to submit his exercise in prescribing to some authority before a living subject has to try the effect of it.

The art of prescribing is hardly to be learnt practically like setting a fracture or opening an abscess, but by carefully watching the combinations of remedies ordered by the Physicians and Surgeons. There is not much progress in the art of prescribing, there are no brilliant discoveries to be made in the combinations of medicines.

New remedies require careful and laborious research from experienced men. H.C.

EXAMINATION NEWS.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

DIPLOMA OF MEMBER.

EXAMINATION ON SURGICAL ANATOMY AND THE PRINCIPLES AND PRACTICE OF SURGERY.

1. What relations do the Median Nerve and its branches bear to the principal arteries of the Arm, Forearm, and Hand? What muscles would be paralyzed by an injury to this nerve in the arm?

2. Describe the operation of Trachotomy—1st, at the lowest, and 2ndly, at the highest point at which the Trachea proper can be opened, mentioning the landmarks which guide the surgeon in the various stages of the operation, and the dangers incidental to it.

3. Give the pathology of the disease which leads to Angular Curvature of the Spine, and the treatment you would adopt for the earlier stages of it.

4. What is Ectropion? Describe the inconveniences attending it, the causes producing it, and the modes of remedying it.

5. Give the Diagnosis, Treatment, and Prognosis of fracture of the Surgical Neck of the Humerus.

6. Describe, first, the symptoms which would lead you to suspect, without local examination, the existence of a strangulated Rupture, and then the characters which such a tumour would present.

EXAMINATION ON THE PRINCIPLES AND PRACTICE OF MEDICINE.

1. What are the various causes of Ascites? What are the symptoms which it produces? How would you recognise its presence, and distinguish it from cystic diseases within the abdomen? and how would you treat it?

2. Discuss the morbid anatomy, symptoms, and treatment of Tubercular Meningitis.

4. What are the several officinal preparations of the following drugs, and what their properties and doses?—Magnesia, Arsenic, Senna, Rhubarb, Colchicum, Conium. Write out in full a prescription for an adult requiring a diuretic medicine.

VIVA VOCE EXAMINATION.

1st. Table, Messrs. Curling and Holmes. Mark out incision for ligature of Common Carolid. What are parts cut through and relations of vessel? Describe operation. What ligature would you use? Put up a fractured jaw, cut splint for same, shewn coin catcher, lion forceps and bullet forceps.

2nd Table, (Clinical) Messrs. Holden, Marshall. Case of enyspted hydrocele of cord. What other hydrocele of cord is there? Enumerate other varieties of hydrocele, how are they caured? What is the fluid of an enyspted hydrocele? How does spermatozoa reach it? How would you treat this case? Why be less inclined to inject than a vaginal hydrocele?

Why is this not a hernia?

Case of osteartheritis of shoulder joint with a large amount of effusion.

How do you diagnose this? What will be the condition of the joint? What of the synovial membrane? Describe the pathology of the disease, where does it commence? How would you treat this case?

3rd Table Messrs. Savory and Cooper-Forster. Shewn comminuted fracture of tibia and fibula with displacement of foot. What is this? How does it occur? How does bony union take place? Which bone is usually broken the highest? How does this affect the displacement? How would you treat it? Do any unsatisfactory conditions follow this fracture? What are they? What is bronchochele? Describe its pathology? What forms exist? In what counties is it most common? With what condition often associated? In which sex most usual? What conditions tend to produce it? Describe its shape and manipular indications, what serious complication may follow? Diagnosis from other tumours of neck. Treatment. What is mychia? What would you call it pathologically? How produced?

NOTES OF THE MONTH.

It having been resolved by the Presidents of the Physical Society that a present should be made to Mr. Williams in recognition of his services as Honorary Accountant to the "Guy's Hospital Gazette" during the first year it was edited by them, as soon as the funds would permit, a present of Dickens' works, bound in half calf, was sent to him, through Mr. Lucas, on January 7th, 1878, and on the 8th a letter of thanks was received by Mr. Lucas from Mr. Williams, in which he said "You must please convey to the Presidents of the Society my hearty thanks for their extremely handsome gift. It will be valued by me no less for the kind feelings which have prompted the Presidents thus to remember me than as a pleasing and substantial measure of the success to which the 'Gazette' must now have attained."

On Saturday, February 9th, at the Physical Society, Mr. Pilkington will read a paper on Antiseptic Surgery. A good discussion is expected to take place afterwards, and a large attendance is anticipated.

GUY'S BIBLE CLASS.—The meetings of this class will in future be held in the Room of the Shipwrecked Mariners' Society, in the Hibernia Chambers, London Bridge, time from 7 to 8 in the evening on alternate Thursdays, commencing on the 14th of February.

PERSISTENCE OF IMAGES IN THE HUMAN EYE.—Dr. Paolo Gorini (*La France Méd.*, 1876, p. 735) tells the following incident which occurred to himself. One night, having fallen asleep while reading a book, he presently awoke, when on looking at the wall opposite his bed, which was illuminated by a lamp near him, he observed it covered with printed characters of large size, forming words regularly disposed and separated by lines like those in the book which he had been reading. Not only could he see the text, but he could distinguish the annotations in smaller characters. The whole appearance was vague and indistinct, but there could be no doubt that the image seen on the wall was that of the pages which he had been reading when he fell asleep. This strange apparition lasted twenty seconds, and in this space of time was reproduced each time at which after closing he again opened his eyes. The incident is interesting as a case of persistent image in the retina. The assertion made a few years ago will be remembered, namely, that the object last appearing before the eyes of a person suddenly dying would leave its image on the retina, and the delusive hope was entertained that photographs of the retina might prove of use in medicolegal cases.

In the *Sanitary Record* for this month Mr. R. Norman Shaw writing "On House drainage by open instead of closed soil-Pipes," says:—The simlest plan is to make a short arm of lead pipe attached direct to the lower portion of the valve box, just where the D trap generally comes, and led through the exterior wall of house in an easy bend, discharging into a funnel-shaped head of lead, forming the top of the soil-pipe. The soil-pipe is three inches in diameter, but might with advantage be less, open at the top and bottom, the lower end terminating about three or four inches below the level of the ground, and directly over a carefully constructed syphon trap of glazed earthenware, but leaving an open space of six or eight inches between the foot of the soil-pipe and the top of the syphon.

The action is extremely simple. When the handle of the closet is pulled up, the contents of the pan rush, unimpeded by any trap, straight through the short arm first mentioned, fall directly down the vertical open soil-pipe, and sweep through the trap with considerable force, into the underground drain; there is no place for any matter to lodge. In the ordinary arrangement the contents of the pan fall into the D trap from a height of only a few inches; this trap has a constant tendency to choke; and it is no exaggeration to say that it is never clean. To ventilate this trap and soil-pipe it has become a custom to put in what are called 'ventilating pipes,' carried to the ridge of the house or to the top of a chimney. They certainly serve to take off the extreme pressure of gas constantly accumulating in the upper part of the soil-pipe, and some of which is generally liberated whenever the handle is pulled up; but that is all they do; in no way can they be said to ventilate the soil-pipe, any more than a room could be said to be ventilated if it had a two-inch pipe inserted in the ceiling; they are better than nothing, and that is all that can be said for them; but in this arrangement no ventilating pipes are required, as the air gets freely to every part.

When first I adopted this arrangement I expected occasionally to find impure matters at the foot of the soil-pipe, and had not fully realised the very cleansing effect of the fall of water. I also thought it probable that this might become coated over with a foul deposit, which might occasionally require to be removed, but after an experience of two years I have never once seen anything objectionable, nor is there the slightest deposit on the upper part of the trap. This trap has never been cleaned out nor touched in any way, nor have any disinfectants ever been poured down any of the closets. Then I was warned by sanitary experts and plumbers alike that there would be sure to be a smell; first, at the grating at level of ground; secondly, at the top of the open soil-pipe; and thirdly (owing to the absence of a trap), in the closets. No one has ever yet been able lo detect the slightest smell at the grating, nor at the top of the soil-pipe, and the closets are exceptionally sweet. They are fitted with 'water waste preventers;' so that when the handle is held up till the water has ceased to flow the air can generally be felt to blow up the pipe, but it never brings with it any smell of an offensive nature."

The following Gentlemen have been admitted Members of the College of Surgeons:—Messrs. Lawson, L.S.A., Deare, Beale, Sykes, Dismorr, Lynn, Nugent, Lee, Fairland, Reynolds, L.S.A., Waddington, L.R.C.P., (Edin.,) Hartley, Reader, L.S.A., F. G. Stewart, L.S.A., A. L. Smith.

The following Gentlemen passed in Surgery:—Messrs. Wainewright, Bates, Collington, Grainger, James, Gray.

The following Gentlemen have passed the Primiary Examination at the College of Surgeons:—Messrs. Smith, Parkinson, Phillips, Langridge, Newnham, Logan, Harries.

In a few days the Library will be in possession of an almost complete series of the Guy's Hospital Gazette. Volume 1 was presented some years ago by the original Editors Messrs. Catelle Jones, Henry Clarke and J. O. Giblin, but since then no bound copy has been added to the Library. The Presidents of the Physical Society have therefore taken steps to add the remaining volumes of this valuable Journal.

Amongst Messrs. Churchills' publications we notice a new book by Dr. Wilks, "Lectures on diseases of the Nervous System." This is a much larger and more extensive work than those excellent "Lectures of the Specific Fevers and Diseases of the Chest" which were first brought out in this Journal. We would remind our readers that these Lectures have been reprinted and can be obtained of Mr. Williams at the Counting House.

The following Guy's Men passed the Matriculation of the University of London in January last:—Messrs. Cuff, Ensor, Hart, Martin, Price, Starling, Stedman, and Nevor.

Correspondence.

REMINISCENCES OF AN EXTERN.

TO THE EDITOR OF "GUY'S HOSPITAL GAZETTE."

SIR,—I am constrained to reply to your Correspondent under the above heading in last month's issue. Having been myself twice extern in the months of May and December, attending seventy cases I presume I may be considered qualified to verify or contradict the statements made in the paper referred to. I feel convinced I represent the experiences of the majority of those who may have so acted in refuting as I can the greater part of his assertions. The expressions are in a measure untrue, and calculated to dishearten those who are eligible to take the appointment. The average of Irish women who have cards, I calculate from statistics before me, to be not more than six per cent, and on only one occasion was I invited to partake of spirit, and then after a protracted primipara case. I find also that my visits were not confined to "filthy garrets half darkened by rags which had been stuffed into the broken window panes," and more frequently I was called to see women who resided in habitable houses in streets, and not in courts, although I may have been led through courts and narrow passages to gain time by saving distance.

The whole thing is an exaggeration, to say the least of it, and had the space it occupies been given to something instructive, many subscribers to the Gazette would have been better pleased, and I should have been saved the trouble of asking you to insert this communication in the February number.

Yours faithfully,

AUDI ALTERAM PARTEM.

Guy's Hospital, January 28, 1878.

The Presidents of the Physical Society beg to acknowledge the Receipt of Subscriptions of 5/6 from the following Gentlemen:—

G. H. Parry
G. C. Steele Perkins
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AIDS TO FORENSIC MEDICINE.

DR. DOUGLAS HEMMING.

Published by Bailliére, Tindall and Cox.

This little book containing only 68 pages, is one of the rapidly increasing series of publications theoretically intended to lead up to the larger treatises. Unfortunately the practical effect is generally an entire neglect of the more complete work, the time to be allotted to the subject being commonly measured by that required to read the 'Aid.'

The promoters of the Series have adapted the suggestive motto *mens sana in corpore sana*, it is to be feared that the tendency of their work is rather to sacrifice poor 'mens' altogether. However, apart from such questions the present epitome has considerable merits, there are some omissions which we think should not have been made even in such a summary; as an instance we may take the case of the fatal dose of opium which is given as 4 grs., no mention being made of the amount fatal to children.

On the other hand we think that many of the poisons mentioned might from their variety well have been omitted, and the space given to other matters.

We notice but few mistakes, still there are some statements requiring revision.

On the whole, though we object to the principle of such books, we think this a favourable specimen of the class.

DR. WILKS'S LECTURES ON MEDICINE, SPECIFIC FEVERS AND DISEASES OF THE CHEST. Reprinted from the "Guy's Gazette." The above valuable Work (price to Guy's Students three shillings), can be had on application to Mr. Henry Williams, at the Counting House.

Guy's, December, 1877.

ANTISEPTIC GAUZE, BORIC LINT, PURE CHLOROFORM,
and other preparations recommended by Professor LISTER, ANHYDROUS ETHER
for producing Anæsthesia, as used by Dr. THOMAS KEITH.
PREPARED BY
J. F. MACFARLAN & Co.,
Manufacturing Chemists, Edinburgh, & 5, Barge Yard, Bucklersbury, London.

Clinical Medicine.

In the course of a clinical lecture on a case of Dysentery Dr. Pavy made the following remarks on the subject of Food.

Persons afflicted with Dysentery frequently find that their troubles are aggravated within a short time after taking food; this cannot possibly be due to the immediate irritant action of the food upon the ulcerated large intestine, but must be due to reflex irritation; the same thing often occurs in people with sensitive alimentary canals, especially after the ingestion of hot drinks.

It is worthy of notice, that, while rice is preferred above all other food by Dysenterics, one of the most common sources of the disease, is the neighbourhood of rice fields after the crop has been gathered. In the treatment of the disease it will be found, that farinaceous foods will be best borne, and afterwards fish, chicken, and butchers' meat, in that order.

For all persons, in health, the more natural the diet, the more completely will the condition of the body conform to the normal type. From structural considerations it is obvious, that a mixed animal and vegetable diet is the proper food of man, except during the first eight or ten months of life, food of a partially solid nature is essential, and must be taken *at regular intervals*. A certain amount is required to be injested in 24 hours, and if this quantity be consumed at one meal, all the energy of the individual is required for its digestion, and he is rendered, for a time, unfit for any other form of work, either mental or physical. But by dividing the same quantity into three or four parts and taking these at regular intervals, there is less strain put upon the digestive powers, and there is still energy left, even during digestion, for the exercise of other faculties.

It is the neglect of this natural rule, that is the commonest cause of chronic dyspepsia, the longer the interval which is allowed to elapse between the meals the larger the quantity required, and it is this compensatory quality, which taken often at a late hour, is the cause of the sleeplessness and discomfort, of which dyspeptics so often complain, and for which they so often have recource to equally injurious stimulants.

The necessity for solid food ceases in acute inflammatory conditions since its digestion is not completed, and the residuum acts as an irritant; but in cases where digestive power is only weakened, and not altogether lost, it is a mistake to withhold solid food entirely; solids of an easily digestible nature should be given, though perhaps fluid nourishment should preponderate. Of animal solids, fish is the most digestible, and of these the best is whiting, "the chicken of fish," followed by sole, turbot, plaice, &c.; salmon, sea trout andred fleshed fish generally are less digestible. The white meat of chicken stands next in order of digestibility and is followed by butchers' meat of which mutton is by far the best as a digestible food. Special dietaries must be observed in various diseases and diatheses; thus—in gout, a highly animalized diet is the worst possible, a preponderance of vegetable food is indicated. This applies also to the uric acid diathesis in which the nitrogenous diet tends to increased acidity and the deposition of uric acid. A vegetable diet will often produce alkalinity of the wine.

In the phosphatic diathesis as much animal food should be given as possible.

In albuminuria and Uræmia the dietetic regulations should be those of gout, &c.

In cases of Dyspepsia, it is so important before laying down regulations as to diet, to recognise the cause of the disorder. When it is caused by vomiting, due to the perverted nerve or muscular fibre long continued, without nausea or loss of flesh and often followed by hunger,—a common condition in young girls—dietetic treatment is useless, antispasmodics and sedatives are indicated. But where vomiting occurs with nausea, especially after some kind of food, or where flatulent distension of the stomach is caused by vegetable foods, digestion, or rather indigestion, is painful, much may be done by careful dieting. Milk and biscuit can always be taken, but the diet should not *be lowered* too much. Digestive power should be raised rather than that the diet should be lowered to the weak digestive power.

Heartburn is commonly caused by fat in a state of change, as in pie-crust, or, the burnt fat upon a roast joint. *Acidity* is the result of sugar in a state of change, as in certain wines, and beers, or pastry. Sugar, that is not undergoing chemical change, does not cause it; thus, in tea and coffee it can be taken in quantity without producing any acidity whatever.

Clinical Surgery.

By Mr. Durham. February 14th, 1878.

The first case brought in was that of a man æt. 37, healthy looking, previous history good, suffering from malignant disease of the ear. "Three years ago he felt a small wart (as he called it) on the top of his right ear. Eight months ago he found it increased in size, gave him a good deal of pain, and secreted a thin ichorous discharge, but was not much indurated. It was then thought to be Rodent Ulcer, or as it is called by those who think it approaches the Carcinomatous character, rodent cancer, and was removed by Mr. Durham. In clinical aspect Rodent Ulcer is intermediate between benign and malignant growths, and might be mistaken for epithelioma, the difference between the two being, that in Rodent Ulcer, as the name implies, there is considerable destruction of tissue, whereas in Epithelioma there is a quantity of

new tissue formation, and under the microscope there are seen small nucleated cells, epithelial in character, having a bird-nest arrangement, but an absence of Fibrous Stroma which occurs in Rodent Ulcer.

The treatment is the same in both cases, namely, remove it.

In this case, in which the disease was removed, wound never entirely healed, and now there is a small spot presenting Epitheliomatous characters. This time Mr. Durham removed it with a pair of curved scissors.

The second case was that of an Ungual Exostosis. Mr. Durham remarked they were not at all uncommon, but occurred more frequently in young women than in men.

It was characterised by pain in the toe nail, which was sometimes thought to be ingrowing, and has been removed, but, of course, without giving any relief.

It can be well understood how painful the slightest pressure would be when the growth was pressing all the sensitive structures of the toe before it.

In this case there had been a history of an accident, the toe had been smashed, and the exostosis grew on the inner side of the nail.

These exostoses consist of bone and cartilage as a rule, but this one was nearly all cartilage; they grow from the ungual phalanx.

Mr. Durham then demonstrated how to remove the toe nail; he condemned the old plan as bungling and inefficient, which consisted in slitting the nail down the middle with a sharp pair of scissors, and then pulling away the pieces with dressing forceps.

His plan consists in thrusting under the nail one of the blades of the dressing forceps, then having pressed down the other blade, grasps the nail firmly, twists it forcibly first to one side and then to the other, and then pulls it away.

This exostosis was gouged out.

The next case was a stricture of the urethra. The patient was in the hospital last October, and was then treated by gradually dilating the stricture with catheters; he left without being perfectly cured. In all these cases there is a tendency for the disease to return, and unless an instrument is passed now and then, the patient soon comes back with a stricture worse than ever.

In this case recurrence has taken place, and he comes in with two strictures instead of one.

As to treatment, alkalies and soothing remedies have been given in the shape of Bromide of Potassium and Citrate of Potash. Mercurial applications have been rubbed on Perinæum to absorb inflammatory products, which have been poured out around the urethra.

A No. 1 Catheter was passed and retained in for some time, but in consequence of its getting blocked up urine flowed by the side.

The above treatment usually succeeds in most cases, but in some, where patient is impatient and the stricture is very old and tough there is so much the more difficulty in treatment. In these cases internal urethrotomy is justifiable and expedient.

But first, what does the passage of a catheter do? It mechanically stretches the parts, but that would not be much good unless it did something more. It sets up a new process of inflammation, which may be proved by the more or less purulent discharge from the urethra following its passage and this new inflammation occuring in the strictured part is followed by absorption.

Now in old indolent ulcers you may apply Lotions and Ointments without any benefit whatever, but if you make a few clean cuts with a sharp scalpel through the hard indurated tissues a new action is taken on, and a healing process commences.

The same thing takes place in Internal Urethrotomy, and its advantages are:—

(1.) It enables a large sized catheter to be passed at once.

(2.) It allows the bladder to be freely relieved.

(3.) It is quicker and more expedient in action.

The operation of Internal Urethrotomy consists in first passing a guide through the stricture and then cut it either from behind forwards, or from before backwards; indeed, some surgeons cut the whole length of the urethra. Now one objection to internal urethrotomy is, that it cuts more or less of the structures external to the urethra, and on this account many good surgeons have never performed the operation.

Mr. Cock had never, because he said he had never seen a proper instrument; but when he saw that of Mr. Durham's construction entirely agreed with it. Mr. Durham's Urethrotome consists of a long curved hollow staff on which a rod fitted with a bulbous extremity slides. From the bulb four little lancet-shaped blades can be made to project by means of a spring. The advantage of four small blades being, that four cuts are made of comparative small extent individually, but cutting on the whole more effectually than one large incision, which would divide structures externally to the urethra.

The hollow staff is first passed through the stricture, the bulb having been next pushed on till arrested, the spring is pressed on, and the little blades cut their way through the stricture.

The last case was that of a man, æt. 37, who ten years ago had a blow on his ankle; the skin was broken and soft parts lacerated. He took no notice of it, and in consequence the ulcer has spread. The last six months it has become worse and is very foul. Mr. Durham remarked, it apparently looked like an Epithelioma.

In this case he considered little good would be done in attempting to cure it, as it would be sure to break

down again as soon as patient got about, so the best thing to do would be to amputate.

If it really were Epithelioma the limb ought to be taken off above the knee, but being doubtful it was removed below.

Anterior and posterior flaps of the same length were made, and the vessels secured by torsion. The Tibia and Fibula were cut obliquely from before backwards, as Mr. Durham thinks the anterior flap lies more evenly, and there is less chance of pus and inflammatory materials bagging, than if the bones were cut straight through.

BY MR. DURHAM. February 20th.

I intend bringing before you to-day cases belonging to that branch of surgery known as Orthopœdic surgery, and I shall endeavour to leave you with the impression that such cases do not require for their treatment any special institutions or instrument makers.

I. *Rickets.* Case of a boy, æt. 3½, who was fairly well until 16 or 18 months ago, when his health became impaired from an attack of measles, and in consequence the proper hardening of the bones did not go on. As a result of this, when the child began to get about and use its legs, the tibiæ and fibulæ became bent. Observe that the bowing of the bones of the leg in these cases is only one expression of a constitutional affection, and on further examination you will find as a rule that the abdomen is swollen, the chest flattened, and the wrists enlarged. This constitutional error should not be overlooked in the treatment.

In the early stages when the deformity is beginning to show itself, much may be done by applying splints to prevent the child from getting about, and so relieve the legs from having to bear the weight of the body.

When, however, considerable deformity exists, more decided measures must be adopted to give the little patient straight limbs. In the first place attempts may be made to straighten the curved bones by forcibly bending them under chloroform, and in some cases this plan proves more or less successful. Should it fail however, recourse must be had to sub-cutaneous osteotomy, which operation will be performed in the present case.

Operation. The child having been placed under chloroform, a small incision was made through the skin over the site of greatest bowing of right tibia, and the bone sawn nearly through. By a little force the remaining bridge of bone was broken across, the risk of lacerating the periosteum being thus less than if the bone were sawn right through. This is a point worth noticing, considering the importance of the periosteum in the reform of bone. The next step was to straighten the fibula by forcibly bending it. Some resistance to this was offered by the tension of the Tendo Achilles, which was accordingly divided sub-cutaneously. The case was then reduced to one of compound fracture of the tibia, with a very small skin wound.

Antiseptic dressings were then applied, the spray having been used throughout, and the limb put up on a straight posterior splint with a rectangular foot-piece.

II. *Talipes* is due to either or both of two conditions:—(*a*) abnormal contraction of one set of muscles, or (*b*) some paralysis of the antagonistic set of muscles. *Talipes Equinus* usually arises from the first of these conditions, the Tendo Achilles being the offending tendon, and as a consequence, the patien walks on the balls of his toes. *Talipes Varus*, in which the sole of the foot looks inwards, may be caused either by abnormal contraction of the tibial muscles, or by paralysis of the peronei. As a rule these cases can be healed very successfully by a simple apparatus in conjunction with good adhesive plaister. A strip of the plaister is applied round the foot, and drawn up the outer side of the leg, where it is secured by means of irregular strips, so that the sole of the foot is drawn into its normal position. This position is then maintained by adjusting a simple splint, consisting of a strip of iron, to run down the back of the leg, with a rectangular foot-piece attached. In those cases in which this method of treatment does not succeed it becomes necessary to divide the contracted tendons.

CASE OF CANCRUM ORIS.

M. S., æt. 2½, was admitted into Doreas Ward under Mr. Howse, January 19, 1878, with a destructive ulceration about the mouth and cheek.

The mother states that the child had fairly good health until twelve days ago, when she was attacked with measles. A week after the commencement of the attack, which was a mild one, the mother noticed a dark spot about the left corner of the mouth. She brought her up on the next day to the out-patient room, when the face was ordered to be poulticed. On the following day the cheek, for some distance around the sore spot, was red and hard.

The child was seen by a general practitioner who said an abscess was coming, and recommended the poulticing to be continued. On the fifth day from the commencement of the disease the child was again brought to the out-patients' room, as the sore had spread and destroyed the tissues of the cheek and lips, and the child was in a very low state (the mother says that she has not been able to feed the child well during the illness). Mr. Jacobson advised immediate admission.

On admission.—Child is very irritable and feverish. Temperature, 100·8°: Pulse, 164. The cheek is in part eaten away by a Phagedaenic inflammation which extends from the left angle of the mouth in all directions, taking a circular course. The parts thus destroyed include a surface considerably larger than a five-shilling

piece, the ulceration taking in the free borders of the upper and lower lips, especially the latter.

A small portion of the bone on the alveolar processes of either jaw is laid bare. The smell, either of the breath or sore, is very fœtid. Mr. Howse had the child put under chloroform directly, and applied strong nitric acid to the surface of the sore inside and outside the mouth; afterwards the whole was touched up with nitrate of silver. The child was afterwards put to bed and ordered beef tea. Eggs and ℥ iij of wine. A dose of castor oil was given in the evening.

January 20. Morning.—Temperature, 99·6: Pulse, 110. Takes food well. Bowels purged after the castor oil. The surface of the sore, which does not appear to have extended at all, is black; there is hardness and redness of the surrounding tissues; the left eye is closed, the eyelids being odematous.

℞. Mist. Potass. Chlor. ℥ ij 4 tis horis. Pulv. Hyd. c Creta gr. i, Sacch. Alb. gr. tj 4 tis horis.

January 21.—Temperature, 100·2°, Pulse, 106. Child lies in a drowsy condition, if disturbed, cries and soon goes off to sleep again. Appetite very good. Bowels regular. Motions very offensive. There is rather more redness and induration about the margins of the wound. The destruction does not appear to have extended at all except a little along the lower lip.

The child being put under chloroform, nitric acid was again applied, followed by the caustic as before.

January 23.—Temperature, 96·8°: Pulse, 120. The surface of the sore is coming away in a slough.

January 24.—The destruction has extended rather along the muous surface of the cheeks. Some of the teeth Bicuspids are loose and almost dropping out.

January 25.—Some of the slough has come away, and the sore seems to have extended somewhat in all directions. The child, however, seems better in herself, sits up in bed and cries all day long. Appetite good; she struggles so much that it is impossible to take her temperature. Skin cool. The cavity of the mouth behind the teeth does not seem to be affected, except a small part of the adjoining portion of the tongue. This afternoon, under chloroform, Mr. Howse removed some of the teeth, which came away quite easily; the slough all round the surface was pulled off and strong Permangate of Potash lotion was well applied.

January 26.—In much the same condition. ℞ Pulv. Ipecac. Co. gr. ij. h.s.s. Rep. Mist. et pulv.

The child remained without much change until January 30, when nitric acid was again applied; the ulceration does not seem to have spread; there is perhaps rather more redness and induration around parts. Temperature normal.

February 1.—Caustic was again well rubbed over surface of sore, which has not spread. Redness and induration in great measure gone.

Febuary 3.—A large loose slough removed from surface of sore. Temperature normal.

February 6.—No more slough has formed; there is a slight healthy purulent discharge from the surface, which is granulating. A small point of the front surface of the lower jaw is sloughing. The child has greatly improved; eats meat heartily.

February 12.—Has continued to go on well; the seat of the disease, which formerly presented, as it were, a punched out appearance, has now greatly improved, and the skin seems to have drawn around and in a great measure closed the gaping wound. The small point of bone has not yet come away, but all the rest of the bone is granulating healthily. Child's general health very good.

B. SCOTT.

PROFESSOR CHARCOT'S CLINIQUE.

(Concluded from page 17.)

Leaving this small room we are taken into the interior of the Epileptic department, where are congregated, patients with all kinds and degrees of Epilepsy; hence one has always an opportunity of seeing fits, from beginning to end. Whilst we were looking on the prostrate form of one of the poor women, who had had a fit just before our entry, a piercing shriek in another part of the same ward quite startled us, and we all proceeded in the direction from whence came the cry. A woman was seen deathly pale, leaning against two nurses who gently laid her down full length on the ground and we watched the fit through all its stages. Going into another ward a young woman suddenly sprang forward towards us and was restrained with difficulty by the attendants. She was no other than Geneviéve, mentioned on page 277 (Case III,) of the English translation of Dr. Charcot's work on Diseases of the Nervous System. She is over 30 years of age and her hysteria dates from the period of puberty. On the present occasion after watching her some time Professor Charcot stepped up to her and pressed on the spinous process of the 7th dorsal vertebræ, she immediately uttered a shrill cry and literally shot down to the ground quite insensible, both eyes deviating to the right, the limbs became rigid, especially left side, foaming at the mouth, stertorous breathing and altogether very much like a real Epileptic. Dr. Charcot now searched for the left ovary with his hand placed at the back part of the brim of the pelvis, and having found it he placed his walking stick upon it and asking us to watch her eyes, leaned so as to exert some pressure on the ovary with the stick. Immediately the eyes returned to their normal position and lost their horrible unconscious stare and the patient looked rational, and answered questions. Then pressure was taken off the walking stick a little, and her senses left her gradually or suddenly, just as this was done slowly or quickly. Sometimes he would take off the pressure whilst she was speaking, and the word she happened to be uttering would be snapped in two, the eyes deviate as before, insensibility and stertor supervene. This was repeated in our presence five or six times and was well worth seeing. The stick was then removed, and she was allowed to lie in this state of insensibility a few minutes. Presently she began to plunge about, writhing and twining into all kinds of contortions, doubling herself up, then suddenly throwing herself backwards into complete opisthotonus or emprosthotonus, so that the attendants, who were strong nurses, were greatly exercised in their task of preventing the patient injuring herself. One of the Interns then got some Nitrite of Amyl and placing a few drops on the lint administered it by inhalation. She speedily flushed and then became quiet and spoke rationally and tried to pull the lint away. On removing it she very soon relapsed into her former state of convulsions, we then personally applied pressure over the left ovary, which seemed somewhat large and swollen, and brought her to herself as Dr. Charcot had done, and we were likewise able at will, by relaxation or compression to let her slip into convulsions or rein her back to rational quietude. After this she was ordered to be placed in bed and a straight waistcoat to be applied. In which she went on struggling, and uttering amorous and obscene language, often becoming perfectly furious and yelling at the top of her voice, mingling wild

laughter with copious tears. Dr. Charcot said this last phase was quite characteristic of Hystero-Epilepsy, being very different from true Epilepsy where the patient in the corresponding stage is apathetic, not delirious. We saw this patient next morning and she was still in the straight waistcoat in bed, but was not so vigorous in her contortions. She is afflicted with Erotomania.

Just after seeing this we saw a typical epileptic fit; and Dr. Charcot took the opportunity of pointing out the salient differences, that is, the tonic rigidity followed by clonic convulsions for a short period; the impossibility of causing any impression on the victim by compressing the ovary, the weary apathetic state in which the patient remained in the last stage, as compared with the wild delirium in the other case. Soon after this we saw another case of Hystero-Epilepsy. Here the young woman was beating a tattoo on the bed alternately with her head and heels in a very rapid manner. Dr. Charcot said this was pathognomic of Hysteria. Another case we were shown was that of a young woman about 28 years of age with hysterical contracture of right lower limb; it was exactly like the picture, on page 292, (fig 23) Dr. Charcot's work already quoted, and which he sketched himself from a patient similarly affected. The toes pointed downwards so that the back of the foot was almost continuous with the line of the tibia; the heel was drawn up as in talipes equinus; the whole limb was so rigid that when the foot was raised it moved the whole of the lower extremity, together with the pelvis as if they formed one solid piece, the limb did not seem hypertrophied or atrophied. The state of rigidity we were told was not only constant during the day never relaxing for one moment, but persisted even during sleep, indeed it only disappeared by giving chloroform to a profound degree of insensibility. This was done to convince us, it was only by administering the anæsthetic to the surgical degree that the limb became supple and pliant; when it did all the joints were flexed very easily and smoothly, indicating perfect freedom from disease, adhesions, &c. As she recovered from the effects of the anæsthetic the limb began to stiffen long before she herself was conscious, and was in exactly the same rigid state as before by the time she was so far recovered as to be able to answer questions rationally.

Another interesting case shewn to us was that of an old woman suffering from Locomotor Ataxy, nearly all of whose joints are dislocated by the disease. The condyles of the femur can be seen and felt all over, and the tibia below moved about in every conceivable direction like a flail. Similarly the shoulders, the head of the humerus can be turned out of its sockets and felt as a round, smooth prominence. She is extremely thin. Dr. Charcot has had casts of this patient's joints sent to the Royal College of Surgeons, London, and to the Owen's College, Manchester.

In another old woman with Locomotor ataxy the disease had affected the bones with a kind of Mollities Ossium, so that they were broken in several places.

These are only a few out of many very interesting cases we saw; but we must leave the rest and say something about the lectures. No one in Paris takes so much trouble in making his lectures interesting and instructive as Dr. Charcot. We do not say this merely from our own observation, but have it on good authority from students—the best judges—in Paris. At the lecture there are present between three and four hundred—old and young—a few lady students can be seen here and there. One has to get there very early to obtain a seat at all. Dr. Charcot lectures in a clear easy style and speaks very distinctly.

In addition to the admirable clinical observations which he makes, he has brought on to the platform the patients themselves, so that all can see—some walk in, others are carried. Hence this is a real bedside lecture. Seeing a case makes far more impression on one's mind than hearing about it. Thus one does not easily forget the gait of an ataxic, after seeing such an one walk.

We were more struck with the great advantage accruing to the students by this bedside demonstration, than by any thing else, and would respectfully call the attention of our staff to the matter. We do not see why our medical patients should not be brought into the Lecture Theatre to illustrate the lecture, and allow facts to flow into the perceptive centres by the visual as well as auditory channel.

At one lecture he had a sort of Magic Lantern, with which he showed some pictures on a large screen fixed on the platform on which he stands whilst lecturing. The room was darkened. First were representations of some so called miraculous cases that occurred in the middle ages. One was a young woman showing her foot and leg rigidly extended, to some doctors who looked puzzled; in the next picture the same young woman was walking about quite well, and everybody astonished. This he said was a case of Hysterical Contracture. Another was the picture of a woman going through all kinds of contortions and dances, being in fact a case of Hystero-Epilepsy. He then showed successively each of the phases of a true Epileptic fit, beginning with the cry, the pallor, the rigidity, the convulsions, the lethargy, and explaining each, this was followed by all the phases in succession of Hystero-Epilepsy, their likeness to and dissimilarity from the corresponding phases of true epilepsy being dwelt upon. All these representations were very true to nature, having been copied from life. It was both amusing and instructive, and met with hearty applause. It was the first time he had shewn this, and we had the honour of being at the rehearsal the day before, when Dr. Charcot informed us it was an experiment he was trying in order to give his audience a clearer perception of what he taught.

We say confidently that had we seen and heard nothing else beyond our experience at the La Salpétrière, it was well worth going to Paris for, and we should strongly recommend all who go to that city to give this renowned hospital, with its almost equally renowned physician a visit; his, is reckoned one of the best Cliniques in Paris.

The Presidents of the Physical Society beg to acknowledge Subscriptions from the following gentlemen:—

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Photographs of the Cartoon "The Operating Theatre, Guy's, 1977," can now be obtained from Sister Luke for the small sum of two shillings. This cartoon contains portraits of the surgical staff, and has additional significance imparted to it by the recent actions of the London University.

The photograph gives a very good idea of the cartoon, and will be valued as a memento of our *Alma Mater*. We understand that the artist, not being able (though wishing), to present a copy to *all* his friends, has taken the opportunity of placing it within their reach, at the cost price.

Photographs of the cartoons, "The Actual Cautery," and "A Circular Amputation" can also be obtained for sixpence a piece.

GUY'S HOSPITAL GAZETTE,
MARCH, 1878.

The Presidents of the Physical Society will be glad if those gentlemen who have not paid their subscriptions for the year 1878, will do so before the next issue.

THE last number of the *Gazette* contains an article of considerable length, upon the "Art of Prescribing." The writer has, in this contribution, raised a question which holds a most important position among enquiries directed to the improvement of practical Medical Education.

Few who have made the trial will deny the extreme difficulty of acquiring even a rudimentary knowledge of Materia Medica, far less a competent aptitude for writing a good prescription.

In the article to which we refer, H. C., himself a "Teacher of Pharmacy," as he informs us, suggests as a remedy for the ignorance which most undoubtedly exists, a thorough and complete mastery of the Pharmacopœia, and refers to Anatomy and Physiology as occupants of a parallel position to that of Pharmacy; on both these points we should join issue with him, and would prefer an entirely different course from the one now proposed. We take up our position upon the following grounds. First, we are totally and absolutely ignorant of the existence of any therapeutic value in a very large proportion of the drugs now included in our Pharmacopœia; again, an equally large proportion are duplicates, *i.e.*, the therapeutical action attributed to them is identical; further, the number of preparations of many substances is wearily multiplied without any corresponding increase in efficiency, and finally to put the matter to a practical test, we would ask, how many of the preparations enrolled in the British Pharmacopœia are ever used by the Medical Profession? We venture to say we are forming a moderate estimate of the fact if we say that not a tithe of the officinal preparations serve any other purpose than that of occupying the time devoted toLectures on Materia Medica or adorning the shelves of a chemist's shop. It is because he knows this, and feels that he is wasting his time in trying to pile up a veritable "dust-heap," that the student finds the time allotted to reading Materia Medica the dreariest and most tedious of all; while work in the dissecting room and hours devoted to Physiology, will well repay him as a Surgeon or Physician.

We would wish to see a new Pharmacopœia containing only those drugs and those preparations of them which are found by the experience of the leaders of our profession to be useful, and let additions be made only after proof that the addenda will really increase our therapeutic resources. Let the multitude of useless and unemployed vehicles be reduced, and only those retained which are necessary to the efficiency of our drugs and the comfort of our patients. The work time of the medical student is not so long, nor are his labours so light that he can afford to have uselsss burdens laid upon him; surely the time now devoted to the attempt, often futile, of learning how tinctures and extracts are prepared by the wholesale druggist, or at what season of the year certain leaves are to be gathered, would be better employed in acquiring familiarity with disease or knowledge of normal functions! The objection that the country practitioner would, by the proposed alterations, be rendered incapable of making up his own prescriptions is easily refuted, for it would entail far less labour to acquire and retain a thorough knowledge of the reformed Pharmacopœia than is now expended in what is forgotten almost as soon as learnt. The fashion of writing long and complicated prescriptions is happily fast disappearing, and with it goes the sole reason for the existence of the majority of our Pharmacopœial preparations.

THE value of the medical degree of the University of London to those who have had the perseverance and ability to obtain it, has for many years been recognised both by the profession and the public. To its influence alone not a few of the most distinguished in the profession owe both their position and their fortune. The graduates of this University have been honoured by baronetcies and orders. They have been elected in numbers to the Fellowship of the Royal Society, and they constitute the majority of the staff of this and many other hospitals. Nor is the power of this degree less felt in the provinces, for there too

it will secure appointments over any other diploma, when personal influence is excluded. Is it not, then, somewhat strange that so few students should be found working for this degree? True, the course is a severe one, the examinations are numerous and the rejections at each alarming; but we doubt if these considerations are alone sufficient to deter so large a majority of students from ever attempting to matriculate. To a very great number the preliminary examinations of the Royal College of Surgeons or of the Apothecaries' Society are the only known portals to the medical profession, and the University of London is an undiscovered pathway. They come up to London to pass the "College and Hall," as did their forefathers, and they are ignorant of any other distinction. Others, again, have been advised by their friends to matriculate, but find that, owing to Chemistry and Natural Philosophy not having been included in their school education, they are without the means of passing. We are pleased to think that for Guy's students, in future, one of the greatest obstructions will be within their power to surmount. A matriculation class, with a staff of thoroughly efficient teachers, has been established in connection with the hospital, and will commence three months before each examination. We understand that instruction for the summer examination will begin on March 25th, and that the class will not be confined to students of the Hospital. At the January examination nine Guy's students presented themselves, and of these eight passed, five being placed in the first division and three in the second. It is a good omen for the future that eight out of nine candidates should have passed from Guy's, at a time when the rejections were as high as seventy per cent.

Physical Society.

On Saturday, Feb. 9th, Mr. C. K. SHAW in the Chair, Mr. GEO. PILKINGTON read a paper on "Antiseptic Surgery."

After some opening remarks, he said that "the essential cause of suppuration in wounds is *decomposition* brought about by the influence of the atmosphere upon the blood and serum retained within them; and in the case of contused wounds, upon portions of tissue destroyed by the violence of the injury.

To prevent this suppuration seemed unattainable, as it was hopeless to attempt to exclude the oxygen, on which suppuration was supposed to depend until the researches of Pasteur, showed it to be dependent on minute organisms contained in the air. The reader of the paper then gave at some length Pasteur's first experiments (published in the Comptes Rendus of the French Academy, in 1859) in which he collected the solid particles of the air by forcing it through a tube, in one end of which was placed a wad of cotton wool, and that when a piece of this cotton wool loaded with air dust was dropped into flasks containing a putrefractive solution, which had been previously boiled, hermetically sealed, and had stood in some cases for months without turbidity or putrefaction occurring, the liquid became mouldy and swarmed with bacteria, these bacteria always appeared at the end of twenty-four to thirty-six hours, the time necessary for their appearance in ordinary air, and that they first appeared near the cotton wool and gradually spread.

He then described Mr. Lund's experiments in the Manchester Infirmary.

An oz. of distilled water was placed in a pint stoppered bottle (in one of the surgical wards), the stopper was removed and the bottle repeatedly shaken about 500 times in the twenty-four hours. After three days there were numerous actively moving vorticelli, with abundance of nomads in ceaseless motion.

Copious extracts from Professor Tyndall's paper published in January 1876, and his paper in the *Nineteenth Century* of January, 1878, were read, Mr. Pilkington laying particular stress on the fact that in the experiments on the Alps, not one of the flasks opened on the Glacier putrified. He then described the methods used by different surgeons to prevent the access of germs to wounds. The enveloping of limbs in thick layers of cotton wool—the pneumatic method of M. Guerin, in which the stump is enveloped in a bag from which the air was drawn, and Lister's method—by surrounding the wound during operation with a cloud of spray, and covering with carbolized gauze afterwards.

The advance of Lister from the first attempt when strong carbolic acid was used, then the paste, where it was mixed with linseed oil and whitening, the carbolic lac plaister, the gauze, and lastly the spray, was described. It claimed for Lister's method:—

(1.) That suppuration is slight.

(2.) That there was almost complete immunity from traumatic fever.

(3.) That erysipelas and pyæmia were reduced to a minimum.

In support of the second, Mr. Pilkington gave the cases in Naaman Ward on January 14th, 1878, in only one of which (a case of Psoas abscess) was there a rise of temperature.

Out of 148 cases operated upon in Naaman and Dorcas wards last year, and treated antiseptically, not a single case of erysipelas or pyæmia occurred, and only five deaths three of those being due to unavoidable causes. He then quoted three cases of amputation, two under the care of Mr. Jacobson, and one under Mr. Lucas, one of which was *operated* upon in erysipelas ward, the other two in the theatre, and in which although in erysipelas ward from time of operation to their discharge as cured, when treated antiseptically, not a single sign of erysipelas was developed, healing going on uninterruptedly, although each patient had had an attack of erysipelas before the operation.

He thought the objection to Lister's method were, (1.) that healing was retarded although slightly; but he was satisfied that primary union did occur under the spray, as he had seen several cases of it.

The expense—especially among the poorer patients who form the bulk of surgical cases in actual practice—the trouble, especially at first entailed by carrying out the "minutiæ of this method—the drawback to certain operations under the spray, such as tying a deep seated artery, or a deeply rooted tumour in a constantly falling cloud of carbolic acid, which tended to convert these operations in something like a dissection under water, while he attached but little importance to the above, one objection remained, which while it should not deter a surgeon from carrying out this method, should make careful to watch the course of his cases day by day, viz., Carboluria, which was especially liable to present itself in cases of a large granulating surface, as in a burn or ulcer, or in those cases which have to be long kept up as in Psoas abscess, and which was especially grave when the cases in which it occurred were complicated with kidney disease.

At the close of his paper Mr. Pilkington exhibited a steak which was wrapped in carbolized gauze on January 1st, which, on removing the gauze and being passed round, seemed quite sweet.

At a Meeting held on February 23rd, Mr. UHTHOFF in the Chair, Mr. WOOLDRIDGE read a paper on "The Physiology of the Nervous System."

The paper began by stating that it did not consist of an epitome of the principles usually enunciated in text books, but was devoted to a consideration of some recent advances on the subject.

1st. As to cause of sleep. The relation of sleep to anæmia of brain was discussed. The view of Reigis as to the influence of products of functional activity was mentioned. An interesting case was quoted from Pflugers Archiv, from a consideration of these the author described his theory of sleep. That sleep was produced by different causes, in different cases. The sleep of extreme exhaustion was best applicable on Reigis' view. The nightly sleep was most probably of the nature of the sleep described in case quoted.

2nd. As to question of Co-ordination of movement and equilibrium. Both these were independent of consciousness. They were reflex acts, the afferent impulses for equilibration were tactile impressions from semicircular canals.

The co-ordinating centre was the cerebellum, this centre was not a single centre but a group tending to prevent rotation in some definite direction.

The other views about the function of cerebellum were discussed, viz., its relation to sensation. The muscular sense and the phrenological hypothesis.

Co-ordination of locomotion was chiefly performed by mid brain. The principle afferent impulses being tactile impressions.

The part played by the spinal cord and Medulla Oblongata in movement and co-ordination were described.

Reflex action. The chief point in this section was the reflex nature—or semi-reflex-nature,—of the acts of micturition, defæcation, parturition, &c. The nervous mechanism of micturition was described and a suggestion was made as to the possibiliy of practically applying these principles in cases of spinal disease and injury.

Inhibition. Its first discovery. Inhibitory centres in frog. Evidence as to their existence in man.

Inhibition by peripheral stimulation and violation. Explanation of mechanism of inhibition, its probability of their being inhibitory cells in cord. Reasons for adopting this view and explanation on this ground of strychnia poison and phenomenon of tickling. The question of the relation of inhibition to self restraint, was also discussed.

The paths of conduction in cord were then described. The lateral columns were the main road of communication with brain. Views as to the segmental nature of the cord, and the anterior and posterior columns being principally commissural.

The question of reflex production of voice and struggles was discussed, especially in connection with the question as to how far these would be considered trustworthy indications of pain.

A good discussion followed.

At the next meeting on Saturday, March 9th, Mr. Manby will read a paper on "Pyæmia."

MEDICAL CASES IN THE HOSPITAL.

BRIGHT WARD.

Cot. 25. Boy, æt. 7.—Two months ago complained of shivering occasionally.

On admission.—Slight lower palpebral œdema. Liver dulness below ribs. Spleen very low down and easily felt; no tenderness. Heart and lungs normal. Urine, 1015, normal. Treatment, Quinine and nourishing diet.

Since admission spleen decreased, but liable to periodical enlargements, especially after food. Blood normal. Arsenic ordered; doing well.

No. 17: æt. 19.—Admitted with a tumour between umbilical and ensiform cartilage tailing towards spleen; pulsation of aorta transmitted. Discovered by a doctor six months ago; since then been decreasing; suffers from pressure in left ovarian region; had globus hystericus for five weeks; hemianesthesia of right side, sensation slightly blunted. Menstruation regular, abdominal parietes over tumour not adherent.

No. 5: æt. 19.—Has been employed in the fields at hard work; for twelve months noticed pain just below Poupart's ligament on right side followed by a swelling; after five months swelling and pain disappeared leaving a soreness and a very small lump; convalescent for three weeks, when old pain and swelling returned, increasing; six to seven weeks ago a tumour appeared above Poupart's ligament; having noticed pain in abdomen for some time previously, lost flesh. Bowels regular.

Per vaginam mass felt through posterior wall, as also per rectum growth from ileum. Tumour not moveable with uterus on bimanual examination.

No. 19: æt. 31.—Abdominal tumour in connection with pregnancy occupying right lumbar region, continuous with liver dulness; tapped and ten ounces of pus withdrawn; now kidney shaped in outline: perinephritic abscess (?)

No. 14: æt. 8.—Psoriasis.

No. 23: æt. 23.—Presystolic apex in connection with chorea of twenty years standing.

No. 9.—Rheumatism with Erythema Nodosum.

No. 24.—A very interesting case of Leukæmia which all should go and see.

THYMOL.

This substance has just been introduced into surgical practice as an antiseptic, and as it is asserted to be a far more potent germ destroyer than carbolic acid, I think a few notes upon the chemistry and pharmacy of this new agent will be acceptable to the readers of the *Gazette*.

Thymol is a homologue of the Phenol series and is represented by the formula $C_{10} H_{14} O$. As met with in commerce it consists of irregular broken crystals nearly transparent and colourless, with an odour of thyme and a sharp aromatic taste.

It possesses considerable chemical interest on account of its numerous combinations; like carbolic acid it unites with sulphuric acid forming thymosulphuric acid from which various salts may be formed. The principal source of Thymol is the essential Oil of Thymol (Thymus Vulgaris), which consists of 40 to 50 per cent of Thymol associated with two other bodies named respectively, Thymene and Cymene.

The essential oil of several other labiate plants contain Thymol and also an East Indian drug derived from Ptychotis ajowan belonging to the umbellifera. Thymol is obtained by treating the essential oil with solution of soda and shaking well, the Thymol only is dissolved by the alkali, and after standing for a short time forms a separate layer; this removed and neutralised with hydrochloric acid yields Thymol which rises to the surface. Another and better method is to expose the oil to a low temperature for a few days, when the Thymol separates in a crystalline state. Thymol is very insoluble in water, the strongest permanent solution which can be made is 1 in 1000, and this strength has been used in the form of spray to destroy the fœtor of a carious nasal bone and preferred to a solution of perman-ganate of potash of the same strength. Rectified spirit dissolves its own weight of Thymol, but most of it is precipitated upon dilution with water. The solvent power of glycerine is not great; 1 of Thymol dissolved in 120 of glycerine and diluted to 600 with water is the glycerine solution which according to Dr. Crocker of University College Hospital possesses special advantages for preparing lotion, the presence of the glycerine obviates the drying effect upon the skin produced by aqueous or spirituous solutions of Thymol alone. The caustic alkalies potash and soda dissolve Thymol readily, 1 grain of caustic soda dissolves 3 grains, and these alkaline solutions may be diluted without separation. Fats and Oils are excellent solvents of Thymol. Ointments containing respectively 1 and 5 per cent are used at University College Hospital. Thymol is also soluble in ether, Chloroform, Benzol and carbon bisulphide.

According to Buchholz the antiseptic power of Thymol is ten times greater than that of carbolic acid, and as it is not poisonous, and possesses an agreeable odour very possibly it may replace that acid in antiseptic surgery.

HENRY COLLIER.

Correspondence.

THE ABUSES OF HOSPITALS.

This is a subject of the greatest importance and it is evident that a radical change in the present system of metropolitan hospital relief is only a matter of time. If any one take the trouble to spend an afternoon at the out-patients' he will see plenty of instances in which the gratuitous relief afforded by the hospital is abused. To give some instances there has been fer some time past a woman attending who wears a silk dress, a jacket hemmed with fur and kid gloves. Yesterday a respectable looking woman came with a long grey ulster jacket, a good hat well trimmed with a feather in it, kid gloves and an expensive brooch and ear-rings. These are not cases picked out specially, they are the first that come to my mind. Many others might be found and amongst them some men, one whom I have seen come in a capital ulster. Domestic servants as a rule have no business there for in the present age they get board, lodging and good wages and could easily afford to pay 2/. for a bottle of medicine, but I would lay down no rule for all their earnings may be employed in keeping their old parents.

These well-to-do people who come to the hospital are nothing more nor less than cheats. In the first place, they obtain both advice and medicine from the hospital under false pretences, for it is an understood thing that the hospital was founded for poor people, but these people who are not poor obtain relief by pretending that they are. Again these people by getting relief prevent some of those who are really poor and deserving from getting it and thus cheat the latter class by preventing them from receiving all the benefit the founder of the hospital intended they should receive. And lastly, not least, these hypocrites cheat the poor practitioner struggling in some wretched neighbourhood for an existence In poor districts such as Bermondsey there are plenty of poor practitioners who only charge eighteen-pence or two-shillings, and it is to these that such people as I have described should go. The marvel to me is that these people have so little pride in them as to be willing to accept medicine gratuitously when they can afford to pay for it.

A very praiseworthy attempt has been made in our hospital to prevent people who can afford to pay, from receiving benefit from the hospital. On the new system only a limited number of new cases can be seen every day, the worst of which are seen by the assistant physician or assistant surgeon and the rest by the house physician or house surgeon. The letters given to the worst cases are available for eight weeks and the other letters for a fortnight.

There is only one objection to this system, and that is that both the number of papers and the time for which they are available is limited. The effect of this is that on some days poor people are sent away because the stock of papers has

been exhausted, although the case may be quite deserving of relief; and on the medical side I know that people poor enough to be helped are unfortunate enough to be refused two or three times in succession. The mistake in limiting the time of the papers was pointed out in the "Gazette" for last month.

I would suggest that the time for which a letter is available and number of letters should both be unlimited, but that the student who has to distribute the papers should be firmly impressed, before he begins his month of office, with the fact that he is only to give papers to those cases which obviously cannot afford to pay for their own relief; of course much would depend on the value of the case, for many people would be able to afford to pay the local practitioner for a trivial case that only lasted a fortnight, whilst they could not afford to pay him for one lasting three or four months.

The time for which the passes are available might be unlimited, provided that it is distinctly understood that directly the patient is well his or her letter is to be cancelled. The objection may be raised that it would be a task unfit for a student to discriminate between poor and not poor, and to enquire into the patient's circumstances. If this be considered a sufficient objection to leaving the matter with the students, I think the hospital would find it economical in the long run to employ two persons, who knew just enough to know a bad case from a trifling one, and whose duty it should be after careful enquiry into the circumstances of the people, to distribute letters to all those whose disease required gratuitous help and to turn the rest away.

Of course it might be disagreeable to the patient to be asked several questions as to whether he could not afford to pay, but it is a true and old proverb that beggars must not be choosers. If this method were systematically carried out I feel sure that the out-patients department would be much less expensive.

I cannot help mentioning that I think the hospital authorities deserve the greatest praise for being among the first to endeavour to remedy one of the greatest evils in London.

REFORMER.

CASE OF CÆSARIAN SECTION.

C. G., æt. 36, admitted into Mary Ward, under Dr. Hicks, on February 8th, 1878.

Patient is married and has had ten children, the last two years ago. Appears to have enjoyed good health until a short time before the last confinement, when she began to be troubled with a discharge of matter and blood from the bowel. This discharge, which she supposed proceeded from "bleeding piles," has continued ever since, and lately in increased quantity. She has not suffered any marked pain with it, and she does not appear to have had any difficulty in defæcation. Her last confinement, as well as all the others, passed off easily. She did not notice anything wrong with the vagina until two months ago. Since then, there has been some discharge from tbe vagina, but she thinks most of the blood has come from the rectum.

She believes herself to be about eight months gone in pregnancy, as she menstruated last at the beginning of June.

On admission.—Patient has apparently been a strong woman of rather small build, but is now much emaciated and weak. Pulse fairly good. Temperature normal. Bowels at times much relaxed. The abdomen is large, being occupied by the pregnant uterus, which reaches within an inch of the margin of the ribs. Placing the palm of the hand upon it, the Rhythmical contractions are very noticeable. The fœtal heart is heard distinctly in the middle line between the umbilicus and the pubes.

On examination per vaginam, the finger meets with a hard nodular mass almost filling the canal, which is apparently confined to the posterior wall. The cervix uteri, which can with difficulty be reached, is soft and apparently free from disease. The rectum is surrounded by cancerous material, and just within the sphincter this is deeply excavated by ulceration.

Dr. Hicks and Dr. Galabin, after consultation, came to the conclusion that the best chance would be given both to mother and child by performing Cæsarian section. The last Tuesday in February was fixed as the day for the operation, but everything was to be in readiness so that should natural labour come on at an earlier date, it might be performed at once. Patient put on ordinary diet and ordered a tonic.

February 10.—Severe diarrhœa has commenced. Starch and opium injection ordered.

February 11th.—Diarrhœa arrested. General condition fairly good.

February 12th, 10 a.m.—Head painful. Temperature, 101·7°: Pulse, 132, weak and compressible. Tongue dry and brown. No particular pain in abdomen.

3.0 p.m.—Dr. Hicks again examined patient and was satisfied that she was going on well, as there was no pain with the uterine contractions.

4.0 p.m.—Severe pain in stomach and sickness have commenced. Pain exacerbated by uterine contractions, which occur every two or three minutes.

6.0 p.m.—The pains continue and are more intense. Patient in a low anxious condition, describes her feelings as those of the first stage of labour.

Dr. Galabin saw her and decided that labour had commenced. Dr. Hicks was telegraphed for, and came down about 7.30 p.m.: he decided to perform Cæsarian section at once.

Patient removed to Clinical Private room.

Operation at 8.0 p.m.—The mixture of Alcohol, Chloroform and Ether was administered. Patient took the anæsthetic remarkably easily, and the pulse kept up well during the whole operation. Subcutaneous injection of 25m. of liquid extract of Ergot.

Incision made from about an inch above umbilicus to pubes. The peritoneal cavity was soon reached as the abdominal walls were very thin. Uterus exposed and incision made along its anterior wall. The placenta was found beneath the line of incision; this was unfortunate, as it increased the risk of hæmorrhage; it was also unexpected, as an examination of the abdomen by auscultation in the morning had led Dr. Hicks to believe that the placenta lay at the back of the uterus. The hand was passed in and the membranes reached at the lower part of the uterine wound; the head, which lay at the fundus, was then seized, and the child extracted. It was not breathing, but strenuous exertions on the part of Mr. Barrs, the House Surgeon, were successful in keeping up the action of the heart until natural respiration was established. After removal of the child the placenta and membranes were stripped off. Relieved of its burden the uterus contracted remarkably well and there was comparatively little hæmorrhage. A catheter (No. 16) was passed through the vagina in order to provide effi-

cient drainage in case of hæmorrhage. The peritoneal margin of the uterine wound was then united by numerous fine silk sutures and the abdominal wound closed by coarser silk. A pad of cotton wool and a flannel bandage was the only dressing applied. The catheter was fixed in the vagina by being strapped to the leg. The operation occupied about two hours.

10.30 p.m.—Has just recovered from the effects of the anæsthetic; seems comfortable and has had no sickness. Pulse, 100, full and with good power.

12.0 *midnight.*—Sickness of a dark bilious fluid has commenced, with much retching. Morphia suppository.

1.30 a.m.—Sickness continues: pulse rising in frequency and losing power. Urine drawn off by silver catheter.

3.30 a.m.—Water drawn off again as she says it gives her pain; sickness and retching continues. Has had no sleep. Much pain and soreness in hypogastrium. Hypodermic injection of Morphia gr. $\frac{1}{3}$.

9.30 a.m.—Has had a little sleep, but the sickness continues at short intervals. Temperature, 101.2°: Pulse, 150, small, weak and compressible. Hypodermic injection of Morphia, gr. $\frac{1}{3}$.

12.0 *noon.*—Still vomiting at intervals. Pulse, 160. Ordered three minims of dilute HCN in half-an-ounce of water every four hours to stop sickness. Vagina syringed out with Iodine water, and catheter removed. Nutrient enema administered composed of egg, brandy and Gosden's fluid meat.

1.30 p.m.—Sickness has ceased. A good deal of hæmorrhage from lower part of external wound; drainage tube introduced and as much as possible of the fluid drawn up by a syringe.

4.0 p.m.—No sickness. Pulse, 160, very weak and small. Has had two more nutrient injections, but only a part has been retained. Vagina syringed out frequently with Iodine lotion. General condition somewhat improved, and patient seems more bright and hopeful.

5.0 p.m.—The last nutrient injection has caused some action of the bowels, and the discharge of a very fœtid fluid motion. Pulse much the same, rapid, weak, and compressible.

7.0 p.m.—Has had a little more sleep at intervals. Temperature, 100°: Pulse, 160, small and weak; Respiration, 32. Patient is becoming somewhat collapsed. Teaspoonful of brandy with ice administered by the mouth at frequent intervals.

8.0 p.m.—The collapse is increasing. Pulse is so small, rapid, and weak, that it is impossible to count it. Patient beginning to wander in her mind; complains of a strange feeling in the abdomen. Brandy still given frequently.

The collapse became more and more intense, and the patient sank about 10.15 p.m.

Post-mortem.—General peritonitis. A small quantity of dirty chocolate coloured pus in the abdominal cavity. Uterus adherent to abdominal wall.

The uterine wound gaping widely, all the stitches having given way. Interior of uterus in condition ordinarily observed shortly after labour.

Recto-vaginal septum converted into a cancerous mass about the size of a small orange, smooth and excavated by ulceration on the rectal side. Judging from post-mortem appearances, the mass was not large enough to have prevented delivery per *vias naturales*. The growth was that described as medullary cancer.

Remarks:—

The choice of operation.—Although the obstruction was not such as would have prevented delivery by craniotomy, the mass would have been so crushed by the passage of the child that it would inevitably have sloughed with an almost certain fatal result to the mother. In this case both mother and child would have been sacrificed. By Cæsarian Section the child would most probably be saved, and very possibly the mother.

The sudden onset of labour.—This probably resulted from the feverish condition she was in on the morning of the operation, which was caused by septic absorption. Consequently the operation was performed under most unfavourable circumstances, at night, in a hurry, and with the patient in a pyrexial condition.

The fatal result may be put down to the persistent retching which continued for about twelve hours; this occasioned the giving way of the uterine sutures, followed by extravasation of discharges into the abdominal cavity, and as a result suppurative peritonitis.

The child is living and appears to be well developed.

JOHN. C. UHTHOFF,
Senior in Charity.

The following letter has been received by a member of our staff, who has very kindly permitted us to publish it. We think it will be read with much interest.

CONSTANTINOPLE,
February 13th, 1878.

MY DEAR DR. ——

After almost unexampled sufferings and privations, glorious battles and long night marches over frozen mountain tops, many thousand feet above the sea level, I reached this city with my general, Baker Pasha, to whose personal staff I have had the honour and pleasure of being attached for more than two months. On the 31st of last month I last wrote to you, I think, from Kamharli redoubts and since then I have indeed seen much of the reality, and something of the romance, of war. On the evening of December 27th, just before dark, our general, Baker Pasha, who had been absent all day rode hurriedly into camp and in a short time I got orders to be ready to march with the troops in half an hour. Well, as soon as it became dark we started with 7 Battalions, 2 small regiments of cavalry, and a battery of artillery, and advanced with great caution on the village of Teskesin, where it was considered possible that the enemy might be; however we found that they were not there, and therefore occupied it at once and held it for 3 days, occupying the time in entrenching positions on the hills behind the village, and sending out troops daily to feel the enemy who made daily demonstrations in our direction across the plain just in front of the village. On the morning of Dec. 31st the enemy made an attack in earnest, and our outposts were driven in at about 6.30 a.m. the noise they made in galloping past the house in which I slept awaking me. I at once got up, we always slept in clothes and boots, mounted my horse and joined Baker Pasha on a little hill a few hundred yards behind the village, and there I saw such a sight as I should think was never beheld before, the whole of the large plain at our feet was filled with the enemy's troops, and in the grey dawn we could see more descending from some hills on the other side of the plain, where they had established positions a day or two before. They at once advanced to attack our positions, their artillery opening briskly on us, we replied and the action soon became general all along the line. Their numbers looked appalling when com-

pared with our little handful of men, (they had 48 strong Battalions of infantry, with a proportionate number of guns and cavalry,) but we had first rate positions carefully chosen, excellent troops, and an English General in whom we felt the most perfect confidence, so we did not feel so much dismayed as you might imagine, and our Pasha's cheerful and confident, almost shall I say jaunty manner, under very heavy fire, reflected itself on the whole army. Well, the action proceeded, and in about two hours the attack was fully developed, and about 11 o'clock the full force of the enemy being apparent, our general withdrew his line to stronger positions a little more to our rear; he was everywhere, all over the field, encouraging the wavering with his voice and presence, and supporting the steadfast, and wherever his blue coat and grey horse appeared during the action it seemed to me that at that point it was as if at least another regiment of reserve had come up, such spirit did the presence of the "Ingleez Pasha" seem to infuse into our brave fellows; well, we went on fighting till dark, and absolutely not only held our own ground but repulsed and silenced the Russians, and then at dark we withdrew our troops from the positions which they had so gallantly held all the day, and which they seemed unwilling to leave, and joined in the general retreat of the Ramharli army under Shiku Pasha, which this battle had been fought so successfully to cover, and had the enemy succeeded in carrying our second positions, or turning them, the retreat must have been cut off, and I should have perhaps been writing from Petersburg, or even Siberia instead of from Constantinople. Our loss was of course very great, about 1 in 3, but we believe that we inflicted on the enemy a loss at least as great as our own number from 2500 to 3000. After this we retired on the sea, and after long and wearisome marches over the almost inaccessible Rhodope Balkans we at length reached the sea in safety, though we had had several battles by the way, and I came on here with Baker Pasha.

At the town of Gimourchena near the coast, our General with Sheeku Bey, a very intelligent and clever officer, who speaks French fluently, and who occupies the important position of chief of the staff, with Captain Burnaby of Khiva fame, who has been our companion since we left Ramharli, were entertained at the Palace of the Greek Archbishop, they slept the night there, and next day, about half an hour after lunch, we marched for the coast. We had not left Gimourchena above half an hour before all three were seized with vomiting, constriction of throat, severe burning pain at the pit of the stomach, intense depression, the usual symptoms in fact of irritant poisoning; we were in a fix, in the middle of a great plain without houses, we could not of course go back, and our next halting place was several hours distant, and the sufferers were becoming rapidly worse, we were fortunately able to procure some salt, which a Turkish soldier generally carries on the march, and with some water I made a good strong solution, which, when administered, acted as an energetic emetic with the best results, although very weak and ill that night, all three were pretty well recovered in the course of 24 hours.

The question arose of course as to how the poison, whatever it was, got into their systems, though under the circumstances we were unable to apply chemical tests, or to go back to get evidence, but I have thought that, while entirely acquiting the Archbishop of any complicity in the act, one of the lower order of priests, who perform menial offices in such houses, and are extremely ignorant and fanatical, had placed a portion of Arsenic or Antimony in the food or wine of which the three partook. Of course the question of a dirty copper saucepan occurred to my mind, as copper vessels generally, however tinned or plated inside, are much used in this country, but I could not find that they had partaken of any dish containing acid, which could have dissolved any portion of the metal, and as they had partaken of dinner the night before, cooked presumably in the same vessels, without bad consequences, I could not myself believe in the copper theory. However, of course, it can never be cleared up how the poison found its way into their systems, and it must remain, in my opinion, as a case of grave suspicion against the Archbishop's household. At Constantinople, four days since, Drs. Armand Leslie and Neville, of the Red Cross Society, with Dr. Kirkpatrick, of the Croissante Rouge, and Mr. Bell, Correspondent of the Illustrated London News, turned up in most miserable plight. They had been taken prisoners at Strigl, near Teskesar, the day after the battle, as they had preferred remaining with the wounded to joining the retreat of the army, their horses and baggage had been taken from them, and they had been compelled to march on foot an immense distance, with barely food enough to support existence, and often grossly ill-treated and insulted by their guard, being on one occasion locked up in a common jail.

Since I have been here I have had the honour of receiving the Medjidie from the hands of Raouf Pasha, Minister for war, at Baker Pasha's recommendation. I have no time to write more as the mail is going.

Believe me, yours very sincerely,
JOHN GILL.

ON DUTY FOR MARCH.

Senior House-Physicians:—Messrs. C. W. Lacey and P. Horrocks.

Junior House-Physician:—Mr. C. Knox Shaw.

Senior House-Surgeons:—Messrs. J. T. Gardner and W. O. James.

Junior House-Surgeon:—Mr. G. A. Wright.

Resident Obstetrics:—Mr. G. Mackern and C. G. W. Lowdell.

DRESSERS FOR THE WEEK.

March 6th.—Mr. Hartley (Mr. Durham).
„ 13th.—Stanley Taylor (Mr. Howse).
„ 20th.—Mr. Jones (Mr. Foster).
„ 27th.—Mr. Russell (Mr. Bryant).

THE NEW CHAPLAIN.—At a Meeting of the Court of Governors, held March 6th, the Rev. H. P. Verdon, Curate of Battersea, was elected Chaplain, in the place of the Rev. Philip Swatman, who has resigned.

ANTISEPTIC GAUZE, BORIC LINT, PURE CHLOROFORM,
and other preparations recommended by Professor LISTER, ANHYDROUS ETHER
for producing Anæsthesia, as used by Dr. THOMAS KEITH.
PREPARED BY
J. F. MACFARLAN & Co.,
Manufacturing Chemists, Edinburgh, & 5, Barge Yard, Bucklersbury, London.

GUY'S HOSPITAL GAZETTE,
APRIL, 1878.

HEMIANALGESIA IN HYSTERIA. METALLO-THERAPY.

By P. HORROCKS, M.B.

Total hemianalgesia or hemianæsthesia is unknown as the result of organic disease. To produce it one has to imagine the whole perceptive faculty of one half the brain to be affected by disease, a condition which, though conceivable, is probably incompatible with life.

Hence this state existing must prove a functional cause. Often in this hysterical condition we also find the special senses affected, dimness of sight, defective smell, deafness, loss of taste, &c., which are rarely met with in anaesthesia due to organic lesions. Hemianalgesia may exist alone or hemianæsthesia alone, or both together. Amblyopia sometimes exists on analgesic side, and with it is often associated achromatopsia—*i.e.*, the patient loses power to distinguish colours, and this always in a definite order from violet through green, red, yellow aud blue.

Amyosthenia, or loss of muscular power, also often exists on same side. Now given a patient complaining of any symptoms, say vomiting, for which no organic disease can be discovered, and whose age, sex, demeanour, point to hysteria, it must be an aid in the diagnosis if one finds her to be analgesic. During the months of January and February of present year I made use of this fact in the Out-Patient Department, and was quite astonished to find how many of those whom I considered hysterical had more or less impaired cutaneous sensibility. I should have less faith in the reality of the condition if I had not in every case eliminated certain objections which might be raised. We all know what a perverse condition hysteria is, how a patient thus afflicted can produce symptoms almost at will; thus such a patient with retention of urine leaving the doctor say that hysterical patients never allowed themselves to be inconvenienced with dribbling of urine, thenceforth developed incontinence. Hence such a patient might steel herself to bear the prick of a needle. To prevent shamming I always use the needle behind the back of the patient whilst pretending to percuss the chest or examine the spine. If not analgesic she is sure to start involuntarily. In that case hysteria is not negatived. Some physicians discredit the fact of hemianalgesia. Dr. Wilks in his admirable work on diseases of the nervous system just published, which all ought to read, says the absence of sensation to pain is very commonly met with in hysterical women. It is probably more common than is generally supposed. Being able to feel, i.e. ordinary sensation to touch not being impaired, and never knowing when anything pricks them, not being hurt, they do not notice their strange insusceptibility. It is a thing to be found out by the physician.

In one of the cases related below, the girl was quite unconscious of any analgesia, and did not know for some time after I had found it out. It has been said that contact of metals with the skin caused algesia to return again, and experiments have been made with success. M. Burg who has paid much attention to this branch, having noticed that the same metal did not act in all cases, but that one had often to try several before hitting on the right one, promulgated the theory that whatever metal was found to remove the analgesia when applied externally must be administered internally for the cure of the disease. The searching for the metal is called metalloscopy, whilst its internal administration is called metallo-therapy. That it has proved successful in practice is doubtful, but there can be no doubt about the action of metals applied externally. Many well authenticated cases are on record. The action is briefly this:—The metals are applied round the arm or leg. In five or ten minutes or longer algesia begins to appear near the coins, spreading in a zone upwards and downwards, until the whole of that half of the body can feel. The skin reddens, punctures now bleed, not having done so before, and the limbs often feel numbed. Curiously enough whilst this is going on the opposite half of the body becomes analgesic, commencing in the spot corresponding to its commencing disappearance on originally analgesic side and spreading *pari passu* with it. Charcot calls this the "phénoméne du transfert." If the metals be left on longer, the analgesia returns again on same side as before, and opposite side becomes normal again, and then they go on fluctuating like the scales of a balance. Sometimes all analgesia disappears, and even if the metals are taken away does not return for hours or even days. Sometimes hemi anœsthesia becomes superadded to the hemianalgesia. Burg calls this "anésthésie de retour." The metals applied near the eye may remove the amblyopia and achromatopsia. Several theories have been offered to explain the action of the metals. Some observers, chiefly English, have tried to explain it by what is called "expectant attention," that is a concentration of the attention on a particular part producing a real occurrence of the phenomena expected. Dr. Charcot very forcibly points out that patients do not know what is expected at least on the first application, and that the transfer phenomenon is not what they can invent or simulate. Others think that they possess an inhibitory power over the centres of perception to pain.

Again an electrical action by the metals has been suggested, and Regnard, a pupil of Charcot's, made some experiments with Du Bois Reymond's galvanometer to demonstrate that electrical currents actually existed—he then constructed a galvanic pile with currents of similar weak intensities, and found that passing these along the affected side caused similar phenomena. He also found that patients sensitive to

a weak current ceased to be so with a stronger one, and became again sensitive to a still stronger current &c. He called these points of nonactivity "neutral points." The following cases are now in the hospital under the care of Dr. Wilks, who has kindly permitted me to publish them :—

E. M., æt. 16, admitted into Mary Ward under the care of Dr. Wilks, August 8th, 1877.

Occupation—School Teacher.

Family History—Father died of consumption. Mother healthy; has eight brothers and sisters, four of whom are not very strong.

Personal History—Scarlatina and measles when a child. Typhoid fever three years ago, and for two years after this she has had "mad fits" every night, beginning at eight p.m. and lasting two or three hours. For last twelve months has had screaming fits occurring irregularly. Menstruation, which commenced when she was fourteen years of age, has always been irregular and the menses scanty. Previous to having typhoid, she had ozœna, and again three months ago. She has been troubled with headaches for some years.

Present Attack—Six weeks ago began to pass her urine involuntarily but painlessly; for last eight days she has suffered much pain along her back.

Condition on admission :—

Medium height, dark hair, good teeth, tongue natural, temperature normal—Viscera normal. Complains of pain on pressing spinal column anywhere. Soon after admission she began to have sickness every day; the incontinence of urine continued; sparks were taken from spine by static electricity; then she began to lose power in her legs, and loss of sensation was noticed in first one limb, then another, sometimes both, sometimes arms and hands, at others legs and feet. Continuous galvanism and faradism were respectively applied, and she became able to get about with crutches. Her symptoms have fluctuated between sickness, rheumatic pains, analgesia, anœsthesia, &c. until the present time, the incontinence of urine being still present and no better. On the 16th January last, she being at this time quite unable to get about even with her crutches, it was noticed that she was totally hemianalgesic on the right side. She also says that she cannot feel her needle or anything with that side, and does not know when she is grasping anything unless she looks—in fact apparently hemianæsthic also. The hemianalgesia which one can test by a needle is quite total, taking in the exact and complete half of the whole of the body, including the head and the special senses—that is to say the right conjunctiva is insensitive to pain—sight, smell, hearing and taste are also imperfect. She however distinguishes different colors quite well.

19th January, two sovereigns were tied round right leg without effect.

20th, four sovereigns laid flat on arm in a circle about three-quarters of an inch apart, and tied on with a piece of tape going twice round. Previous to placing them on, the arm was wetted with salt and water. She was watched and tested repeatedly for some hours with no result, being perfectly hemianalgesic the whole time, whilst the corresponding part of opposite arm always retained its normal sensation to pain.

In the same manner, silver, copper, zinc, tin, lead and iron, and various combinations of these, were respectively tried day by day without any very satisfactory result. On one occasion she had some slight sensation to pain in palm of right hand, but no corresponding loss in palm of left hand.

She remained with no diminution in the hemianalgesia and hemianæsthesia in Mary ward until the beginning of March, when she went home.

E. B., æt. 26, admitted January 15th, 1878, under Dr. Braxton Hicks. Married. Eight months ago had a full time baby, still born. Previously quite regular, since has had pain before and during each menstrual period. Pain on back and loins on attempting to walk.

On admission is healthy looking. A soft illdefined swelling is felt in groin, painful on pressure. Temperature 100.4°; Pulse 98; catamenia lasted four days, quantity normal.

The uterus is of normal size and anteflexed. The sound passes normal length. Some erosions of cervix, She was treated with tonics, blisters, poultices and local applications to cervix, but did not seem much improved. Was hyperæsthetic on left side of abdomen.

February 14th, Mr. Uhthoff, the Senior in Charity, having told me she was hysterical, I under pretence of examining her back ran a needle into the left side of her neck, and then her head, loins, &c.; she did not exhibit the least manifestation of pain, and indeed was quite unaware that anything was being done beyond examining her chest. The needle was thrust right into the skin. But on merely touching her witn it on the right side, she at once exclaimed that I was pricking her. Next day Dr. Wilks saw her, she was totally hemianalgesic, but not anæsthetic. There is also considerable amyosthenia on left side, though she can move her limbs freely. Slight deafness left side. Can see with left eye, but cannot distinguish colors with it. She says red is pink, yellow is white, pink is whitish, blue is green. Sees her error at once, when allowed to look with both eyes. Cannot distinguish between heat and cold on any part of left half of body.

21st. Two gold coins (sovereigns) fastened on left forearm, midway between elbow and wrist. After twelve minutes had elapsed she felt the prick of a needle just below coins; after sixteen feels needle nearer wrist, and there is some analgesia on corresponding part of right arm. No bleeding. Twenty-three minutes, bleeding at four punctures.

Thirty-five, no sensation in left forearm, but feels needle about lower part of biceps, with corresponding diminution on opposite side. Rosy blush all over arm,

probably due to the continued pricking.

Forty-two minutes, feels at lower end of left radius —impaired at opposite side.

Complains of numbness in hand and arm.

Sixty minutes, feels near shoulder left side—impaired opposite side. Says now she cannot feel anything she touches. In fact she is now anæsthetic as well as analgesic on left side.

February 22nd. Passed a bad night; rigors several times during the night. Intense headache. Pain on pressure in right inguinal region. Temperature 100. Pulse 150. Sweating profusely. Face flushed. Several of the punctures on left arm seem to have bled under the skin, causing bruise like patches the size of a sixpence.

Evening, Temperature 99°. Pulse 100.

February 23rd, Temperature 100°. Pulse 108.

Feels better. Abdomen less tender.

Anæsthetic and analgesic whole of left side. Two lead discs (pure metal) applied round left forearm. No effect until half an hour had elapsed, when she could feel a little on anterior surface of wrist—no loss on opposite side. Discs kept on forty-five minutes, but no further effect.

Evening, Temperature 101, Pulse 140. Respiration 36. Perspiring freely.

February 25th. Two iron discs applied for thirty minutes on left arm, when sensation to pain returned along inner side of biceps, with impaired sensation on corresponding part of right arm.

February 26th. No anæsthesia nor analgesia in head, face, neck and trunk of body, whilst both are present in left arm and left leg, commencing at margin of deltoid and in groin respectively.

Six sovereigns applied round left forearm.

In ten minutes two punctures bled, but no sensation.

In fifteen, no difference.

In twenty, algesia returned at outer margin of biceps, with impairment on opposite side corresponding.

In twenty-five minutes analgesia again over biceps, but algesia over upper part of supinator longus.

In thirty minutes. Zone of algesia on same level with loss on opposite side.

In thirty-two, zone no longer exists, but there are patches of algesia at this level.

In forty-five minutes, algesia returned along middle of forearm, with impairment of opposite side.

Experiments are still being made. She is in No. 18 bed, Mary Ward, and is taking chloride of gold and sodium, in doses of one-eighth of a grain three times a day.

In another case in Bright Ward, where we found analgesia, which was unknown to the patient and not complained of, though she was also anæsthetic, and told us of this. Iron discs were applied for half an hour and sensation to pain returned, and has not disappeared since. It did not disappear on the opposite side. Anæsthesia disappeared at same time.

CASE OF INTESTINAL OBSTRUCTION FROM IMPACTED GALL STONE.

We are indebted to Mr. Carrington for notes of the following case.

A. W., æt. 77. Has led an active life. Said to have always suffered from "sluggish liver." On several occasions has had attacks of what probably was biliary colic, and has been jaundiced at these times. The last occasion was 18 months ago. Since has had attacks of abdominal pain on several occasions. Always constipated.

February 22nd. Has felt very unwell for the last few days, and in the night vomited her food.

February 24th. Diarrhœa.

February 25th. Suddenly taken with severe pain in epigastrium, and continuous vomiting throughout the day. In the evening the pain became intense, she was more or less collapsed, with a weak, thready pulse. There was no hernia. She was placed in bed and opium administered, and in the morning was fairly comfortable, vomiting having ceased.

February 27th. Vomiting returned on previous night. Great pain in epigastrium and left hypochondrium. Well nourished. No jaundice. Abdomen tender, especially over left hypochondrium, full but not distended. Liver not enlarged. No distension of stomach. No lumps to be made out by palpation in abdomen. Vomit bilious. Heart and lungs normal. Temperature, 98·8°. Pulse, 80. Urine not high coloured. From this time was kept under the influence of morphia, and ordered fluid diet, with brandy. She vomited regularly every 8 or 9 hours, and after the first three days the vomited matter became distinctly stercoraceous. The peritonitis, which was at first limited to the upper part of the abdomen, became general. Never any febrile temperature or pulse.

March 10th. Vomiting had ceased for two days, and a very small amount of fæcal matter was passed per anum.

March 12th. No vomiting.

March 13th. Still no vomiting. Has been gradually getting more reduced in flesh and strength.

March 14th. Has been in pain most of the afternoon. Suddenly seized with intense abdominal pain, causing her to cry out continuously. This lasted about an hour, and she died.

Autopsy. 22 hours after death. Abdomen tympanitic, fair amount of fat. General peritonitis, coils of intestine adherent. Intestinal contents universally extravasated, but mostly in right hypochondrium. In this region the peritoneal adhesions were of some date. Stomach and liver healthy. Gall bladder thick and contracted. There is a large hole, which will admit the finger, communicating with the adherent duodenum, elsewhere the adhesions to the under surface of the liver have given way, and there is a large irregular communication with the peritoneal cavity. The hepatic duct was pervious, and fluid injected into the cystic readily made its way into the remains of the gall bladder. Three small gall stones were found loose in the peritoneal cavity in the immediate neighbourhood of the gall bladder, and a large one weighing 294 grains and measuring 1½ inches by 1 inch was found in the lowest part of the ileum just above the valve.

The history of the case would seem to be this:—Formation of a large concretion in the gall bladder, its discharge through its wall into the duodenum, its impaction at the lowest part of the ileum and finally rupture of

adhesion of gall bladder, with intestinal extravasation Clinically it was one of intestinal obstruction, and the diagnosis seemed to be, between what it eventually turned out to be, and a malignant stricture; low down, because of the stercoraceous vomiting, and of the fact that the amount of urine passed was normal. There was a strong leaning in favour of impacted gall stone, on account of the previous history, and the probability of such an occurence at this age. There had never been any gastric symptoms, such as hæmatemesis or pain after food, so that the possibility of a fistulous communication between the stomach and colon, due to malignant disease, was discarded, and this seemed to be further falsified by the fact that the stercoraceous vomit was always semifluid, without solid parts, and that there were no copious gaseous eructations. Prior to the attack, the bowels had acted regularly, so that fæcal accumulation was not probable. Other causes of acute obstruction, such as volvulus, intussusception and internal strangulation were discarded on account of the want of suddenness of onset and the age of the patient.

A CASE OF HYDATID IN THE ORBIT.

UNDER THE CARE OF MR. HIGGENS.

The patient, William T., æt. 55, was first seen April 3rd, 1877. He said that six years before he had injured the left side of the head but had quite recovered, and was at work as usual when four years ago the left eye began to protrude. The protrusion had gradually increased until within the last three months during which it had become more rapid. The left eye when examined was seen to protrude and to diverge somewhat. All the movements except upwards being much impaired. A firm and somewhat nodulated growth could be felt between the orbital margin and the globe at its lower and outer part. The pupil re-acted to light and he could distinguish large objects, though he was unable to count fingers. The eyelids could be closed over the globe. Examined by the ophthalmoscope there was some haziness of the optic disc and swelling. The surrounding retina being also cloudy. The retinal veins were dilated. The right eye was perfectly healthy. He was treated for some time with eight grain doses of Iodide of Potassium but without improvement. October 10th, 1877. The following is the report. He has much pain in the left orbit, temple and side of the nose. The eyelids on that side are œdematous. He has bare perception of light in the left eye. Examined with the ophthalmoscope the optic disc is bluish white, the retinal veins gorged and the arteries smaller than natural.

On December the 31st, 1877, as the growth continued to increase and a distinct sense of fluctuation could be felt, the growth was opened and a small quantity of purulent matter escaped followed by a large quantity of transparent spherical bodies. The eye-ball returned to its normal position and the movements were much improved. At that time the optic disc was completely atrophied and there was much irregularity of the choroidal pigment. After this time the cavity suppurated and large quantities of hydatids escaped from time to time with the discharge. The parts round became œdematous and the eye-ball again protracted, but all this subsided and when last seen on February the 25th of this year the wound had completely closed and the eye-ball was in its proper position, though its movements were still impaired.

Remarks.—The above, besides being an example of a very rare situation for hydatids to occur in, shows very well the effect of pressure on the optic nerve. It first produced congestion of the disc which was followed by atrophy without previous swellings. If the patient would have had the tumour opened when the disc was only congested, his eye-sight would probably have been to a large extent restored instead of hopelessly lost, as it was after atrophy had taken place.

JOHN W. MEEK, L.R.C.P.

Correspondence.

[TO THE EDITOR OF THE GUY'S HOSPITAL GAZETTE.]

THE M.D. DEGREE.

SIR,—It cannot, we think, be denied that the primary enthusiasm of an embryonic practitioner, before it has been damped by an acquaintance with Osteology, and finally extinguished by an application to Materia Medica, is directed towards the possession of the title of Doctor. After years of study, we will suppose him possessed of the London University Diploma. Now it must be a somewhat aggravating circumstance that when for the first time he displays his plate to an admiring public, he should find an Edinburgh man next door, a Brussels over the way, and an Aberdeen round the corner. But this, in the present state of things, will of necessity occur. The difficulty of obtaining an English degree is so great that but few men possess it.

Oxford we have recently learnt is practically defunct. Cambridge and London yearly grant a few M.D.'s, but at Cambridge residence, and at London, the severity of the Examinations, and the vexatious regulations, oppose.

The path of the medical graduate is strewn with thorns, instead of lined with roses.

Now what students and general practitioners want is an University where the M.D. degree can be obtained after the usual 4 or 5 years Hospital course, and without residence, the bug-bear of the profession. The London University partially fulfils these requirements, but as its graduates are about as rare as Cleopatra's Needles, it can hardly be said to answer the purpose.

Besides, we have a sort of idea that London M.D.'s should be immediately provided for on an Hospital Staff, where scope would be given for their scientific intellects, which the bronchitis and belly-aches of private practice hardly affords.

It has been said "Never point out an evil without suggesting a remedy."

Perhaps a new University at Manchester would supply such a degree. The Examinations need not necessarily be so difficult as the London, and the time (which is also money to most students) for obtaining the degree should be shorter.

In this way migration to the far north, the Emerald Isle, and the Continent would be checked, and the London University men partially satisfied.

Another idea has been started for everyone to call himself

Doctor, and place his professional titles after his name. This we fancy, without disposing of the difficulty, would entail a considerable enlargement of existing door-plates.

But in whatever way the question is settled, and to do justice to it leading articles for a century would hardly suffice, really matters but little, for success, in private practice at least, depends far more upon a man's manner and practical knowledge, than upon the possession of any particular diploma.—I am, Sir, yours, &c., J. W. B.

[TO THE EDITOR OF THE GUY'S HOSPITAL GAZETTE.]

Sir,—Had I been spared the time I would have commented on H. C.'s communication last month. I would now only say that after the good article in your March number it is unnecessary. Having recently left the Hospital for country practice, I may add, that in my opinion,—and probably many others have experienced the same—the art of prescribing or methods of combining drugs, either compatible or incompatible, is better learnt at practice in a Dispensary, than by *plodding* over a book on Materia Medica; I myself would rather trust to knowledge gained in a General Practitioner's Surgery before entering Guy's, than to an imperfect remembrance of Materia Medica, which subject I knew *pretty well* a year or two ago, though I always failed to see its advantage.

As H. C. is evidently a Dispenser at the Hospital, I am questioning myself if he would not return a prescription, although *signed by authority*, containing Liquor Potassæ and Tr. Hyoscyam. If I remember rightly one at least of the Surgeons to Guy's admits the use of the two together, and I think experience of results may go in favour of their combination. There are other equally or more efficient combinations taught to be incompatible. Enclosing my card, I am,

AN OLD GUY'S MAN.

TO THE EDITOR OF "GUY'S HOSPITAL GAZETTE."

SIR,—Permit the insertion of a few remarks, which, while they may receive the approbation of most of my fellow students, will I doubt not evoke the displeasure of a certain few.

It may be argued that the subject I wish to bring before you should be beneath the consideration of any right-thinking man. So it would had its publicity been limited within certain bounds. But since its extension has gone so far as to elicit public attention, and the condemnation which it (public attention) unscrupulously inflicts upon a community which should otherwise be directed upon a decided minority in that community; the subject, I think, then becomes deserving in some way a more than cursory consideration, and an indepeudent expression on the part of the majority upon the actions of those who have been the primary cause of the recent public indignation.

It must be with feelings of extreme regret, nay, almost disgust, that we have read and heard lately of the proceedings of a certain class of indecorous and despicable *gentlemen* who unfortunately can claim the appellation of "Medical Students." Such irrational and illogical proceedings as those recently indulged in at Spurgeon's Lecture Room, call forth nothing but the most explicit and emphatic condemnation of those "blackguard gentlemen" to use the mild designation of a member of the staff) who figured recently at the Lambeth Police Court. However much might have been the disapproval on the part of the opposition upon the objects of the meeting, nothing could possibly justify the extreme measures adopted of "breaking chairs and windows," smoking, hootings, and howlings, and other such obstructive measures; means indeed which meet their parallel only in those lowest of lowly-organized gangs constructed to obstruct political and electioneering meetings; where might and not right gains the day; where physical force supplants and not supplies the absence of common sense. But surely such measures are not those which should characterise an assembly of medical students, and if there do exist such students who choose to debase themselves to the grade of senseless blackguards, they deserve the vigorous condemnation of the public, and the severest censure of those whose profession they desecrate; and if they prefer the Police Court and its concomitants, let them most emphatically, I say, lose all their previous professional connections, that they no longer remain to defame and defile by their contemptible conduct the honour and welfare of those who strive to elevate and dignify that profession which deserves their highest esteem and regard.

Yours,

MALO MORI QUON FORDARI.

NOTES OF THE MONTH.

A correspondent to the *Daily News* writes thus:—"I have a nephew who is a medical student. He informs me that he received a circular requesting his attendance at the meeting in Trafalgar Square. He went there for 'a lark,' and met many of his fellow students, who were there for the same purpose, without any political feeling. He said it was rare fun, he thoroughly enjoyed himself, and helped to carry the Turkish flag to the Admiralty. This young man has been plucked over and over again, as, according to your paper, appears to be the case with an immense number of students. This is not surprising, for young men who take pleasure and waste their time in 'larking,' as many medical students appear to do, can have but very poor brains. They ought to be carefully looked after by their parents."

The above letter refers to the meeting of Medical Students in Trafalgar Square, in the early part of the month. We are bound to confess that we believe that the same feelings that actuated the correspondent's nephew, incited many other students to "demonstrate" for the honour (*sic.*) of their country. We cannot deprecate too strongly the practise of medical students mixing themselves in such affairs.

It does their country no good, and only brings them into disrepute. Ungentlemanly conduct and "bear fighting" only lend to perpetuate the belief in the existtence of that class of student depicted by Charles Dickens in "The Pickwick Papers." Demonstrations for, or against, any object can have no weight when got up by the "rowdy" element of the London Hospitals.

Mr. Edward Amphlett, M.A., M.B., (Cantab.) F.R.C.S., has has been appointed Assistant Surgeon to Charing Cross Hospital.

Mr. F. C. Coley, M.R.C.S., L.R.C.P., has been appointed House Physician to the Hospital for Women, Soho Square.

The Michael Harris Prize has been awarded to Mr. W. E. Fielden.

The Rev. P. H. Verdon has resigned the Chaplaincy to the Hospital, to which he was recently appointed. The Rev. R. J. Coward, late Vicar of St. Paul's, Worcester, is at present doing the duty.

Dr. Blundell's collection of Obstetric specimens and models, formerly attached to the chair of Midwifery at Guy's, has been purchased by the London School of Medicine for Women.

RESIDENT DRESSERS FOR APRIL.

April 3rd, Mr. Stuart, (Mr. Durham. April 10th, Mr. Crooke, (Mr. Howse). April 17th, Mr. Morley, (Mr. Cooper-Forster). April 24th, Mr. Phillipps, (Mr. Bryant).

GUY'S HOSPITAL GAZETTE,
APRIL, 1878.

ALL the details of the inner life of the Hospital are of interest to us, as students who have within its walls to learn everything that we shall require to be acquainted with as practitioners of the future. Of these, few are of more importance than the nursing arrangements, more especially to those of us who as House Physicians, House Surgeons, or Dressers, are daily liable to have our best efforts for the welfare of the patients frustrated by bad nursing. All who have had the responsible charge of patients, know what a load of anxiety and petty personal supervision is lifted from one's shoulders by the knowledge that a thoroughly reliable nurse is at the bedside.

With a view of improving this important department of hospital management, the authorities have recently made some sweeping changes, most of them apparently steps in the right direction. The nurses are no longer left to learn their duties haphazard, but systematic instruction is afforded them by lectures and classes, whilst much of the purely domestic work of the wards is relegated to other hands; so that we have not now to call a nurse from her pail and scrubbing brush to help in a dressing. But at the same time, one important part of the new system, if judged by the light of its practical working, appears to be open to very grave objections; we allude to the plan of nursing by probationers. As matters now stand one division of a ward is under the care of a trained nurse and the other under a probationer, with apparently precisely the same amount of responsibility. The inexperienced probationer, who probably has never been within hospital walls in her life before, performs exactly the same duties, has exactly the same power, and is addressed by the same appellation as the thoroughly trained nurse, who has had years of experience, and is thoroughly well instructed in all her work. The practical result in most wards may be readily imagined. The probationer being in no recognised way under the direction of her more experienced companion, usually considers herself quite as good as she is, and continuous personal supervision by the sister, being neither possible nor indeed desirable, manages matters after her own sweet will; and her ignorance, and often presumption, lead her into endless mistakes, only the most serious of which probably ever come to light. One instance of this kind, of so flagrant a character that the House Surgeon felt it his duty to make a special report upon it, recently occurred, and every dresser in the surgical wards could relate cases of a similar nature. Of course in some instances in which the probationer possessing more common sense and less combativeness than is usual amongst the daughters of Eve, is not above taking the advice of the trained nurse, things after a time work fairly smoothly, but this is unfortunately rather the exception than the rule, the two being too often hopelessly at loggerheads. Even under the most favourable circumstances, a dresser has to give his personal supervision to many minute details, with which, under ordinary circumstances he ought to have no concern. One cannot possibly expect a woman who is only commencing to learn her duties, to be capable of taking the responsible charge of a case. The Medical Council might on a similar principle appoint a First Year's Man as full Dresser.

The matter is certainly worthy of careful attention, and the Hospital authorities who have all through shown an earnest desire to place the nursing staff on the best basis, will, we are sure, not ignore the experience of those who have the opportunity of watching the working of the system from a somewhat different standpoint to their own.

DR. HOWARD'S METHOD OF ARTIFICIAL RESPIRATION.

Dr. Howard, the Medical Officer of Health for New York, observing some faults in the methods usually adopted for inducing artificial respiration, viz., the processes of Marshall Hall and Sylvester, has suggested a method by which these faults can be obviated. This has been adopted at New York with excellent results, and on March 13th Dr. Howard explained his process of inducing artificial respiration, to a large audience in the Operating Theatre, somewhat in the following terms.

All may meet with suspended animation, and unfortunately, always at an inopportune moment. Opinions differ as to the value of electricity, the cold bath, the warm bath, and other kinds of treatment, but in apnoea from any cause, whether hanging, suffocation or drowning, all are agreed upon one point that *the* remedy is artificial respiration.

In inducing artificial respiration three things have to be considered.

(1) How to make a clear tract from the lips to the lungs.

(2) How to exert most compression upon the chest.

(3) How to procure most expansion.

It is in these three points that the methods of Marshall Hall and Sylvester fail. Let us first consider the method of Marshall Hall.

(*a*) The patient is placed on his abdomen, with the head and shoulders resting upon a pillow, and pressure is made on the back with a view to removal of fluids which may have accumulated in the throat or stomach. To this part of the process I would make three objections.

(1) The mouth is here the highest and the fluid the lowest point, so that the fluid to reach the mouth must flow upwards.

(2) By this process the food may be forced up to the pharynx, forced into the glottis, and thus complete, the suffocation.

(3) The thorax would be in the form of an arch, and therefore, when pressure is made on the back, it is the less effectual from there being no counterpressure.

(*b*) The fluids supposed to be thus removed from the chest and stomach, the patient is now placed on his back, that inspiration may take place, after which he is seized by the shoulder and hip and rolled over on his face until completely pronated, pressure being then made on the side and back, that the inspiration may be more complete. This process is repeated 15 times in the minute. To this part of the process I would make the following objections.

(1) The patient is first placed on his face, so that the tongue may gravitate downwards away from the larynx, but when expiration is complete, he is sharply supinated, the tongue thus falling over the larynx at that moment when he alone can inspire, in other words just at the wrong moment.

(2) As the patient lies upon his back, a certain degree of flexion of the neck exists, this being a most inconvenient attitude both for breathing and swallowing.

(3) The same objection may be again made, that owing to there being no counterpressure, there is less effect in the pressure made upon the sides and back.

(4) The position and the downward pressure of the head and chest tend to embarrass the freedom of the diaphragm.

We will now consider Sylvester's method.

(*a*) To get rid of the fluids from the stomach and throat the same process is adopted as in the method of Marshall Hall, and the same objections may consequently be made.

(*b*) The body is now placed on the back with the shoulders raised, and the tongue is drawn forwards and clamped between the teeth, a not very humane proceeding, and one which may be compared to the removal of a cork from the neck of a bottle to place it in the mouth. The operator then stands behind the patient's head, grasps his arms above the elbows, and draws them upwards and outwards so as to expand the chest well. When inspiration has occurred the movement is reversed, and firm pressure is made against the sides of the chest that expiration may be effected. This process is repeated 15 times per minute.

My objections to this are the following.

(1) The compression is ineffectual owing to the position of the operator. Standing, as he does, behind the head of the patient, the force of the wrists alone can be brought to bear, and is diminished by the fact that the point upon which pressure is made can only just be reached.

(2) Pressure can only be made downwards and inwards, instead of upwards and inwards, as it should be, besides which the hand of the patient intervenes between the pressing hand and the pressed chest.

(3) The absence of counterpressure.

(4) The embarrassment of diaphragm and flexion of neck as in the previous method.

The method which I have adopted in preference to these two is as follows.

(*a*) To remove the fluid from the throat and stomach, strip the patient to the waist, and then place him on his face, with a firm pad (consisting of his rolled up coat, or other convenient article,) beneath the epigastrium, matters being so arranged that the mouth is the lowest part of the track along which the fluid has to pass. The operator now gets above the patient, and placing one hand over the stomach and the other slightly lower down, throws his whole weight upon him suddenly, at the same time exerting pressure with his hand in an upward direction, both drainage and ejection being thus most efficiently produced.

(*b*) To remove obstruction from the mouth and throat the tongue is drawn forwards by means of a piece of cotton cloth, and held protruded at either angle of the mouth. Any bystander may relieve the operator of the charge of the tongue.

(*c*) Turn the patient on his back, a firm pillow being placed under the epigastrium, and the head being the most dependent part. The tongue is kept protruded as already explained, and the neck and pharynx are now extended backwards so that the whole respiratory tract is as open and free as it is possible for it to be. Seize the patient's wrists and bring them back above the head, until the two wrists cross each other, the arms being held in this position by a bystander, or fastened in some manner. The costal origins of the Latissimus Dorsi are brought into play, a greater

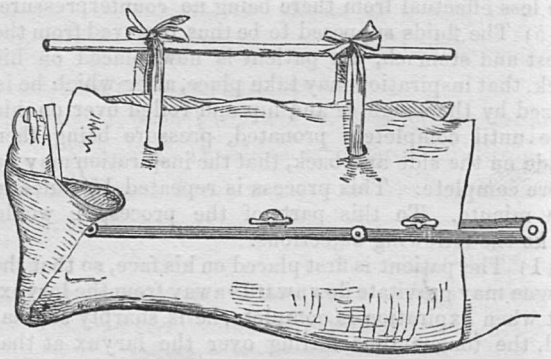
amount of thoracic expansion being thus obtained than by the methods of Sylvester or Marshall Hall.

(*d*) To effect expiration. The patient being placed in the position described in c, compression is made by kneeling at the side of, or better, astride the patient, and placing the balls of the thumbs on the costoxiphoid ligaments, so that the fingers fall into the intercostal spaces. The hands being then kept as a fixed point, the operator throws his whole weight downwards, whilst he slowly counts 1, 2, 3, increasing then the pressure. He then suddenly brings himself back into his former position, inspiration being now heard to occur with an audible blowing sound. This process may be slightly modified in the case of asphyxia in newly born infants, the ball of the thumb being placed posteriorly and effecting, counterpressure while the fingers are parallel to the ribs, in the intercostal spaces and thus compress the chest. This may be done between the thighs of the mother, before the umbilical cord is cut, and whenever there is the slightest gasp, divide the cord. You are thus waiting on nature, and by carefully regulating the process and assisting her, the feeble gasp is gradually deepened into a full respiration, the dark, livid colour leaves the face, the lips become recoloured, and life is, as it were, given to the child. At the same time, flagellation, the cold or warm bath, electricity, can be tried if thought advisable. Another advantage of this process is that it can be continued for two hours or more if necessary, whereas the processes of Marshall Hall and Sylvester are most fatiguing, and can scarcely be carried on for half-an-hour by the same person.

[We are indebted to Mr. Montague Lubbock for the above.]

A NEW METHOD OF MAKING A BAVARIAN SPLINT.

A description of the following modification, of the ordinary method of making a Bavarian Splint, may prove interesting to many of the readers of the *Gazette*. Its essential principle consists in the substitution of an iron clamp for stitches, in bringing the layers of flannel together in front of the leg. The instrument used is simple in construction, and may be conveniently likened to a carpenter's ordinary two foot rule doubled up, with the flat surface applied to the front of the leg and foot. It is provided with two joints to enable it to be adapted to the curve of the limb. When applied, the hinge in the centre corresponds to the lower edge of the Patella; the lower joint, with the angle formed by the junction of the dorsum of the foot and the crest of the tibia; and the upper joint, with a point some 6 or 7 inches higher. The inner edges are made rough, and embrace the layers of flannel on either side, and are brought firmly together by means of three screws placed at convenient intervals, and furnished with sharp points to pierce the flannel. The splint may be constructed as follows. The outer layer of flannel being laid on a table, the gum and chalk is spread over it with a spatula, and the inner layer laid evenly over this. The whole is now placed beneath the limb, the edges brought together round it, and suspended in the usual manner to a strong iron cradle, by means of bandage. The clamp is now applied to the front of the limb, the upper borders of the layers of flannel being embraced by the centre hinge, and the edges of the clamp brought together precisely in the same manner as the legs of a pair of compasses. The two upper screws are first inserted, but not screwed home, until the foot piece is completed. This is accomplished in the following manner:—Draw the flannel tightly against the plantar surface of the foot, taking care that the latter is brought to a right angle to the leg, and make a crease on either side, and fold back neatly the now four folded flannel on to the dorsum, and with a pair of scissors remove the two inner of the four folds, by cutting downwards towards the heel along the creases, and remove the superfluous thicknesses of the flannel. Remove a small strip of the inner of the two layers now left, and stick down the remaining one with a little gum and chalk. We now have a triangular piece of flannel coming up from the sole along the dorsum on either side, the apices of which must be enclosed within the clamp; all three screws may now be firmly tightened, and to keep the foot at a right angle to the leg, the lowest screw may be conveniently tied to the middle one with a piece of bandage.



I have been led to devise this plan from personal experience of the long time required to make a splint by the old method. With a little practice the whole thing may be thus done in less than ten minutes, to say nothing of the replacing of the ugly, and painful plantar seam, by a flat even sole; and the avoidance of the numerous pricks experienced by the patient during the old process of sewing and cutting off. Moreover the after trimming is greatly facilitated by the even thin edge which the splint presents after cutting off the superfluous flannel with a sharp knife.

[We have to thank Mr. L. M. Bowen Jones for the above description of his ingenious invention. For the sketch we are indebted to Mr. W. F. Hearnden.]

Physical Society.

A meeting of the Physical Society was held on March 9th, Mr. Horrocks in the chair. Mr. G. Mackern read Mr. Manby's paper on "Pyæmia" of which the following is an abstract—

"Pyæmia, Septicæmia and Traumatic Fever are closely allied and often pass into each other. The distinct rise and defervescence of temperature in the last serve to distinguish it from the other two in which an oscillating chart is characteristic. Traumatic fever is due to the absorption of unaltered inflammatory products, septicæmia to the absorption of these when containing certain ill understood abnormal substances, whilst pyæmia is septicæmia plus secondary deposits in various tissues. The infective virus is nodoubt produced by some fermentative change at an injured part. Is the presence of bacteria a necessary part of this change? Probably so. Hiller's experiments upon the subject. Bacteria described. These are entirely absent from the healthy organism. Although some connection with the external air is probably necessary for the contamination of an organism, yet this need not be at an external wound, the lungs being a possible medium of infection. Case related in illustration. In such a case it is probable that germs absorbed by the lungs are developed into bacteria at the seat of injury. Certain observations seem to prove that wherever arrest of circulation from any cause exists, septicæmic changes may follow. This theory would explain pyæmia without an external wound, as well as its very frequent occurrence after injury to bone. Centres of infection, due to injury, are acted upon by substances called antiseptics, which not only kill the bacteria, but render the inflammatory exudation an unsuitable soil for their further production. Cases bearing upon this point related. Secondary metastatic abscesses may form in any organ, but most commonly in lungs, liver and joints, and are probably due to infective emboli. Localisation of these discussed. Bryant's table shews that in 203 cases of pyæmia the lungs were involved in 186, and the liver in 55. In pyæmia there is a special tendency to affection of the joints, and the sterno-clavicular joint is said to be the most frequently implicated.

Subacute or chronic pyæmia may exist, as hospital sore throat, aniline dye poisoning, gonorrhæal rheumatism. Pyæmia may follow scarlet fever or acute rheumatism. The symptoms of pyæmia are those of severe inflammatory fever, with an oscillating temperature ranging five or six degrees above normal. In some cases jaundice is found, due, according to Frerichs, to an impaired consumption of bile in the blood. Peculiar rashes may develop, classified by Lee as follows,—1. A pustular eruption. 2. Irregular spots of congestion. 3. Congested patches with dark centres tending to pass rapidly into mortification. A peculiar pyæmic odour is mentioned by some. Symptoms of peritonitis or of myocarditis may also be met with.

Treatment. Good food, stimulants, small and frequent doses of opium, quinine, the sulphites of soda, alkaline salts. Abscesses as soon as diagnosed, should be opened antiseptically. Amputation may be performed in chronic cases, but is inadmissible in acute.

The special liability to pyæmia after compound fractures and injuries to bone."

A discussion followed, and after a vote of thanks to the reader and writer of the paper, the meeting adjourned.

The last meeting of the Session was held on Saturday, March 23rd, Dr. Wilks in the chair. Mr. Sheldon read a paper upon "Interstitial Nephritis," which will be printed *in extenso* in the Gazette at the earliest opportunity. A discussion followed, and a vote of thanks to Mr. Sheldon was carried. Mr. Lucas then read the report of the Society, which was very satisfactory. The Society was flourishing, the quality of papers good, the debates spirited, the funds in a satisfactory condition, and the Gazette prosperous, financially and otherwise.

The names of the Prizemen were then announced as follows:—

For the best paper read before the Society, Mr. G. H. Russell, "Intestinal Obstruction."

For the second paper, Mr. John Poland, "Secondary Hæmorrhage."

For the member most distinguished in the debates, Mr. G. H. Russell; but as that gentleman had already obtained the prize for the best paper, this prize was awarded to Mr. W. H. White.

For the best essay upon the "Localisation of Nerve Functions in the Brain," Mr. Beavan Rake.

Proxime accessit, Mr. F. T. Bayes.

For the best essay upon the "Pathology of Chorea," Mr. J. T. J. Morrison.

The following gentlemen were announced as new Presidents. Messrs. Poland, Russell, Wooldridge, W. H. White, Morrison, Maylard, Sheldon, Scott, and the prizemen.

Mr. Wainwright then congratulated the Prizemen. Messrs. Russell, White, Rake and Morrison replied.

Mr. Shaw proposed a vote of thanks to the Treasurer for the kind interest exhibited by him in the Society. The Treasurer replied, expressing the pleasure it gave him, even as a listener, to attend the meetings of the Society. He was glad to hear of its success, and assured the members that he felt a warm interest in it as in every institution connected with the Hospital.

Mr. Downes proposed a vote of thanks to the Presidents of the Society, which was seconded by Mr. White.

Mr. Davy replied.

Mr. Horrocks proposed a vote of thanks to the Secretaries, which was seconded by Mr. Morrison.

Mr. Lucas replied, and humorously reviewed the history of medicine and surgery, both well represented in the Society. He impressed upon all the necessity of utilising this opportunity of practising the art of public speaking, most valuable in after years.

Mr. Symonds replied, and expressed a hope that papers would be more freely forthcoming next year than they had been last.

Mr. Mackern proposed a vote of thanks to Dr. Wilks, which was seconded by Mr. Wright.

Dr. Wilks in reply, referred to the inauguration of the session six months ago. Time is measured by the work we do, and the last six months must mean much to the earnest first year's student, attending lectures, visiting the wards, and seeing in all a new life. To the senior man, who has perhaps been clinical clerk or dresser, it may also have been of great importance, often changing him from an inexperienced student to a capital surgeon. The unfortunate man who takes no interest in any of these things, is never to be found at the Physical, so cannot blush at the pity expressed for him. The Society is an index of the School, the best men always being found amongst its members. From Mr. Lucas' banter about medicine and surgery, we should draw the useful moral, that all specialism is bad. Was glad to hear of the Society's prosperous condition, and now its meetings were over, hoped to meet the members often in the Wards.

The meeting then terminated.

Football.

INTER HOSPITAL CHALLENGE CUP TIES.

GUY'S *v.* St. GEORGE'S.

This match was played on Tuesday February 5th at Blackheath. Veitch winning the toss elected to defend the upper goal and thus had the advantage of the slight breeze. Hunt started the ball for George's, but Stokes by a long drop returned it well into touch, George's forward were quicker in getting to work and carried the ball towards the Guy's goal and aided by a good run by Colledge succeeded in scoring a touchdown. Stokes dropped out and a scrimmage was formed in neutral territory. Stokes by a dodgy run carried the ball nearer the George's goal but a long drop by Colledge soon equalized matters. Veitch now made a short run which he ended by a drop which gave Guy's the advantage and their forward led by Scott, Boswell, and Fraser forced George's back. Then Veitch getting the ball passed to Jackson who again passed to Stokes who after a short run was collared. Ozanne now relieved his side but the George's forward were unable to increase the advantage. Jackson now got the ball and was only collared in time to save Guy's scoring a try. Juke now by dint of hard play took the ball away but he was safely held by Stokes. Guy's forwards now coming with a rush carried the ball almost over the George's goal line but Mackay made a drop which Stokes would have caught had he not been charged down by Taylor who was off side. Soon after Jackson made his mark but the place was not successful. Shortly afterwards he again got the ball and dodging the George's backs, grounded the ball between the posts. The try however was unsuccessful. Mackay dropped out but shortly afterwards Stokes having the ball passed to him by Veitch gained a second try for Guy's. The place was a failure though it was a splendid attempt. Half time was now called. Stokes kicked off and the Guy's forwards following up caused the scrimmage to be formed in the George's territory. Veitch now made a neat run but Taylor by two good runs took the ball out of danger. Mackay soon got a chance to drop a goal but only succeeded in making Guy's touchdown. Colledge soon after carried the ball into our twenty-five. Then succeeded a series of loose scrimmages in which Guy's got the advantage. Ozanne next made his mark but Mackay's kick was a failure Stokes catching the the ball and dropping it well up the ground. A neat run by Taylor was spoiled by his omission to drop at the right moment. Lister distinguished himself by a short run but he was held and soon afterwards Guy's had to touchdown. A long drop by Colledge forced Guy's to touch down again. Stokes dropped out and the scrimmage was formed about the half way line. Guy's forwards now playing splendidly carried the ball into their opponents twenty-five and it was almost over the line when Ozanne ran it out. Again the forwards led by Boswell, Fraser and Pink took the ball back but could not score before time was thus called. Guy's thus won by two tries and a touchdown to four touchdowns. *Guy's.*—Q. R. Veitch, (capt). A. H. Jackson, (½ backs). L. Stokes, (¾ back.) E. Penny, E. Roper, (backs). I. H. Lister, I. A. Fraser, A. Scott, I. Boswell, I. L. Jones, A. Jeyes, C. Pink, W. Growse, G. R. Green, R. Cuff, (forwards).

GUY'S *v.* KING'S.

This match was played at Stamford Brook on the 19th of February. Stokes kicked off for Guy's and the return drop being charged down, a series of well contested scrimmages ensued. The first incident was a run by Bond, who was held before he had gone far. Soon after Stokes made his mark though his drop was erratic and went far into touch. Soon King's had to touch down. For a short time the ball remained in the centre, but two long drops by Stokes gave Guy's the advantage, and Veitch getting the ball ran in and obtained the first try for Guy's. The place failed and King's touched the ball down. The drop out by Penny was responded to by a drop by Stokes, and Guy's soon forced the ball towards their opponents goal. A drop by Corner and a run by Cornish improved the position of King's, but Jackson, Veitch and Stokes were on the alert, and the opposite backs could not get away. A run by Jones took the ball into the King's twenty-five, after a little scrimmaging Veitch got the ball and made a drop at goal which passed just outside the posts. Half time was now called. Penny's kick off was well returned by Stokes, and soon after a drop by the same player caused King's to touch down. After some scrimmaging in the King's territory Penny relieved his side, but Stokes getting the ball ran in for Guy's. The place failing King's touched down. For a short time the fight was maintained in neutral territory, but a run by Veitch and a drop by Stokes caused King's to touch down again. King's were now hard pressed, and C. Penny making his mark Stokes nearly kicked a goal, the ball hitting one of the posts. Runs by Bond and Penny kept Guy's back, but they could not get away owing to the splendid manner in which the Guy's forwards lined across the ground. Stokes soon ran in for a second time but the ball was brought back; he however again got the ball and outpacing Bond and Penny, got a try between the posts which he afterwards converted into a goal. Just before time was called Roper made a brilliant run of three quarters the length of the ground, and eluding the King's backs got a try between the posts. This Stokes converted into a goal and directly afterwards time was called. Guy's thus won by 2 goals, 2 tries and 6 touchdowns to *nil*. The Guy's forwards played well all through the match and were so well on the ball that the King's backs could not get away. Penny, Davies and Bond did their best to ward off defeat but all to no purpose.

Guy's.—Q. R. Veitch, (capt). A. H. Jackson, (½ backs). S. Stokes, (¾ back). E. Penny, E. Roper, (Backs). I. H. Lister, I. A. Fraser, A. Scott, I. Boswell, J. L. Jones, F. Wilkinson, A. Jeyes, C. Pink, W. Growse, R. Cuff, (forwards).

GUY'S *v.* ST. THOMAS'S.

This match was played at Stamford Brook on Friday, 22nd of February. Leatham kicked off for St. Thomas's and a scrimmage was formed in Guy's half. The Guy's forwards were gradually forced back, and although Stokes tried hard he could not get away. After some hard play the ball was taken into Guy's territory and they were compelled to touch down. Stokes dropped out and the Guy's forwards playing hard in the loose scrimmages carried the ball towards the St. Thomas's line and Lister dribbling the ball over forced Butler to touch down. The game up to half time was even, Jackson and Veitch making some good runs for Guy's while Jeffreys, Wallace and Leatham were in good form for St. Thomas's. After change of ends, Stokes kicked off and the ball was returned by Jeffreys; Jackson and White distinguished themselves by runs for their respective sides. The Thomas's forwards then playing splendidly, forced Guy's to touch down twice in quick succession. Stokes now made a very good run and would have obtained a try had he not been held by Leatham after passing all the other backs. Guy's men being stale after their match on Tuesday were unable to stand against the compact play of the St. Thomas's forwards, and after a short scrimmage Price obtained a try for St. Thomas's. The place was a failure, Guy's being forced to touch down. Soon after Leatham made a splendid run but was held by Stokes. Jackson then made a run but was held by Butler. Guy's were soon after forced to touch down, and notwithstanding all their efforts were unable to equalize matters. St. Thomas's won by 1 try and 7 touchdowns to 1 touchdown.

Guy's.—Q. R. Veitch, (capt). A. H. Jackson, (½ backs). L. Stokes, (¾ back). E. Penny, E. Roper, (backs). I. H. Lister, I. A. Fraser, A. Scott, I. Boswell, F. Wilkinson, I. L. Jones, A. Jeyes, C. Pink, W. Growse, R. Cuff, (forwards).

STATISTICAL REPORT OF LYING-IN CHARITY FOR JANUARY, 1878.

Number of women attended				208
Recovered	206			
Died	2			
				208
Single Births	206			206
Dual	2			4
				210
Women at end of 1st confinement				33
" " 2nd "				32
" " 3rd "				30
" " 4th "				20
" " 5th "				20
" " 6th "				15
" " 7th "				17
" " 8th "				9
" " 9th "				10
" " 10th "				9
" " 11th "				3
" " 12th "				5
" " 13th "				2
" " 14th "				1
" " 15th "				2
				208
Children at full time.				
Males alive	101			
Males dead	3			207
Females alive	98			
Females dead	5			
Premature Children.				
Males alive				0
Males dead				2
Females alive				1
Females dead				0
Total number of children				210
Alive	200			210
Dead	10			
Presentations.				
Vertex (Occipito posterior 6, Placenta Prævia 1)	201			
Breech	6			
Knee	1			
Vertex and hand	1			
Brow	1			
	210			
Operations.				
Forceps	5			
Partial Version	1			
				6
Externs attended.				
Mr. W. D. Smallpiece				56
Mr. G. L. Downes				42
Mr. A. Jeyes				42
Mr. H. Moor				34
Mr. R. Steele				32
Mr. J. G. Barns				2
				208

JOHN C. UHTHOFF,
Junior Obstetric Resident for January.

SURGERY AND MEDICINE IN 1525. WORKS PRINTED IN SOUTHWARK.

By W. RENDLE.

Soon after printing was first introduced into this country, Southwark became a celebrated place for the beauty and clearness of the work done. Amongst these early books, are two which should be interesting to the profession, and especially to "Guy's," close to which locality they were printed, (in black letter), one in 1525, the other in 1526 and 1527. The first is "The noble experyence of the virtuous handy wark of surgerie" and recounts the experience of "the very experte olde doctours and maysters" whose names are given. The other is "The grete herball which giveth parfyt knowledge and understanding of all manner of herbes and their gracyous vertues." They are "imprynted at London in Southwark by Peter Treveris, dwellynge in the synge of the wodowes," (wild man of the woods). Together, these books shew the state of medical and surgical knowledge at the time, and are worth looking at, if only to measure the methods used, and the advance of the profession into a science, from superstitious empiricism and astrology. It must be granted that there was much of shrewd practical knowledge, some instances of which might be thoughtfully studied even now. One I give by way of example. I have seen the author, "when a surgeon made hys boast to heel in eight days a person that hath broken hys leg or arm; *and this to prove, a dog's leg was broken and was medled thus*, a powder of bole armeniac, amber, wall roots and barley meal were mixed with the white of

an egg, and laid on the dog's leg, and it was splinted. The splints were taken off on the eighth day, and the dog's leg was whole." Before I give an acconnt of the books, let me give the mode of examination and legal entry into the profession, 3 Hen. VIII., 1511-12, in the original words, "Forasmuch as the Science and Conyng of Physicke and Surgerie, to the perfecte knowledge whereof be requisite both great lernyng and ripe experience, is dayly within the relm exercysed by a grete multitude of ignorant persons of whom the great part have no manner of insight in the same nor in any other kynde of lernynge. Some also can no letters in the Booke (cannot read). Be it enacted, that no persone within the Citie of London nor within seven myles of the same take upon hym to exercyse or occupy as a physician or surgeon excepte he be firste examyned, approved and admitted by the Bishop of London or by the Deane of Paules for the tyme being, callynge to him or them foure doctoures of physicke for examinacyon and gevyng letters testimonials under their seale to hym that they shall so approve." Life of Colet, 1724, page 459.

The book on Surgery begins with "The Laude of our Savyour Chryst Jhesu, and the honoure of his blessed moder, our Lady Saint Mary," and refers to "many ignorant who will meddle with the noble syence." Young students, masters and servants of "barbers and surgyens" are to "rede with diligence the lytell boke." A picture of a skeleton begins the thirteen pages devoted to "the Anathomie of membres, skynne, fleshe, vaynes, senowys and boyns," the brain and the "pan which kepeth ye braynes togyder" are rapidly surveyed, as are also the dura and pia mater, and the "vaynes and vayne stringys" which come through holes in the undermost bones, and within this pan is the "dwellynge of ye reasonable soule." Surrounding the rude anatomical figure are the signs of the zodiac, and figures of the principal planets, with lines from each to the parts supposed to be specially under the guidance or influence of these astrological signs, all which would have to be well studied by any one who would be an especially good doctor; and indeed, astrological medicine was then taught in our Universities. Moreover the remedies were to be carefully gathered and compounded with due regard to celestial influences. So late as 1632, a herb woman for physical herbs was one of the *quasi* staff of St. Thomas' Hospital, and after that the surgeon's position was so low, that if he failed to unite a fracture, the order of 1677 appointed that a bonesetter should have, at his own house, cases discharged by the surgeons as incurable, and "if he cures them, he shall be paid." Again, in 1638, a salary of £20 was given for the special cure of scalled heads, but this is outside our immediate subject. The book of Surgery is freely embellished with somewhat rude plates of surgical instruments, and the methods of using them, in a style the exact reverse of that of our own James Blundell, whose maxim "*arte non vi*" was always ringing through the Lecturing Theatre. A most formidable instrument, shaped like an old printing press, is fixed upon a man's head for the purpose of trephining his "brain pan." The Herball contains a Materia Medica and Practice of Medicine in one. Drawings of plants and other remedies are given, and under each head, how and when the plant is to be gathered, whether it is hot or dry, or cold or moist, and in what degree, how it is to be used, and for what complaints each is "sovereign remedy," or "hath divine vertue." There is a very important and elaborate chapter upon urine, which would have delighted our wonderfully regretted men, Bright and Addison. This chapter has prefixed a picture of the doctor, regarding with critical eye, the water brought by a young woman who stands before him.

The book ends with a pious exhortation "O ye worthy reders or practicyens to whome this noble volume is preset, I beseche you, take intellygence and beholde ye workes and operacyons of Almighty God which hath endewed his symple creature mankynde with the graces of ye Holy Goost to have parfyte knowlege and understandyne of the vertue of all manner of herbes and trees in this booke comprehendyd, and ought to be notyfyed and marked, in whome is repended ye hevenly gyftes by the eternall Kynge, to whom be laude and prayse everlastynge. Amen."

The Presidents of the Physical Society beg to acknowledge Subscriptions from the following gentlemen :—

Chubb, J. R.	Paul, F. T.
Eastes, Dr.	Flannagan, H.
Sells, H. T.	Todd, H.
Roper, Mr.	Keep, C. H.
Grove, Dr.	Taylor, B. R.
Lawson, G. L. C.	Williams, Dr.
French, A. M.	Dalton, Dr.
Eastes, G.	Fasken, E.
Bovill, H. H.	Roots, W. H.
Shillingford, F. N.	Birkett, Dr.
Gillingham, Dr.	Pickstock, Dr.
Davis, G.	...

ACKNOWLEDGED COMMUNICATIONS.

Communications have been received from, Dr. Bull, Messrs, Amphlett, Horrocks, Carrington, Manby, Bowen Jones Lubbock, and the secretary of the London School of Homœopathy.

Mr. Rendle is thanked for his communication. We shall be glad to receive further notes upon the subject.

Books, etc. received. Sanitary Record, Students' Journal.

ANTISEPTIC GAUZE, BORIC LINT, PURE CHLOROFORM,
and other preparations recommended by Professor LISTER, ANHYDROUS ETHER
for producing Anæsthesia, as used by Dr. THOMAS KEITH.
PREPARED BY
J. F. MACFARLAN & Co.,
Manufacturing Chemists, Edinburgh, & 5, Barge Yard, Bucklersbury, London.

GUY'S HOSPITAL GAZETTE,
MAY, 1878.

ADULT SPINAL PARALYSIS.

The pathology of diseases of the spinal cord does not seem to have been investigated before the present century, and it is only within the last fifty years that many affections well-known at the present time have been understood. It was thus at a quite recent date (1858) that Locomotor Ataxy was shown to be due to Sclerosis in the posterior columns of the cord, the ataxic symptoms being caused by sclerotic change in the wedge shaped bands at their inner margin (bands of Goll), Duchenne believing the cells of the posterior vesicular column of Clarke to be also affected, and that degeneration might thence spread through the intermediate tract to the lateral columns, or anteriorly to the anterior Cornua producing lateral or anterior Sclerosis. Ascending degenerative changes due to a lesion of the cord were also shown to extend along the bands of Goll, whilst descending degeneration passed mainly along the posterior part of the lateral column. The lesions in the anterolateral columns to which the rhythmical tremors, paralysis, and rigidity of lateral Sclerosis are due, and those in the brain and spinal cord producing the same tremors, the drawling speech, the ocular affections and other symptoms of Multiple Sclerosis are similary a discovery of late years. Again that the tremors are perhaps due to the cylinder axes being deprived of their medullary sheath and lying denuded in the foci of Sclerosis, the Nystagmus to Sclerotic patches in the Pons Varolii or Medulla Oblongata, the Amblyopia to patches along the Optic nerve are but late suggestions of Charcot. The lesions of the Anterior Cornua have also been recently investigated; Wasting Palsy has but within a short time been shown to be due to atrophy of the large cells and nerve tubules with sclerotic hypertrophy of the Neuroglia in the anterior Cornua; in Infantile Paralysis similar lesions have been found, while Duchenne has described two other affections termed by him respectively "Acute anterior spinal Paralysis," and "Subacute general anterior spinal Paralysis," in which the same motor cells seem to be involved. The first, which seems to be but Infantile Paralysis occurring later in life, is termed by Dr. Bristowe "Adult Spinal Paralysis," this being the disease which will be specially considered in the following remarks, whilst to the second Dr. Bristowe gives the name of "General Spinal Paralysis," but as this name has already been given by Calmeil to "General Paralysis of the Insane" some other would perhaps be preferable, the mind according to Duchenne being unaffected in this disease. It will be seen that the patient referred to below presents the symptoms of Adult Spinal Paralysis, from which affection he would seem to be suffering, but as different opinions have been held as to its nature this article must be looked upon as only the statement of a few points in favour of such a diagnosis. Adult Spinal Paralysis, or "Acute anterior spinal Paralysis" is characterised by the following symptoms, which will be seen to correspond to those of Infantile Paralysis:

1.—The onset is usually marked by febrile symptoms lasting from a few hours to a few days, which may however be absent, pain in the limbs, and often, if not always, a sensation of numbness and tingling.

2.—Motor Paralysis comes on suddenly, and within a short time (usually 24 or 48 hours) the Paralysis attains its full degree and extent. It may only affect certain groups of muscles (most often those of the right lower, or of the upper extremity), but may involve the body and the four extremities.

3.—There are no spasmodic movements, trembling or rigidity.

4.—Cutaneous sensibility is unimpared, but pain is now almost if not altogether absent.

5.—Electric contractility (impaired from the first), and reflex activity are rapidly lost in the Paralysed muscles.

6.—Neither the rectum nor bladder are paralysed, the urine does not become ammoniacal, nor do eschars form on the Sacrum.

7.—The muscles, which are flaccid from the beginning rapidly waste (more rapildy than after nerve injury).

8.—The mental faculties are unaffected.

9.—The lesion does not extend to the Medulla oblongata, as in the subacute variety, and consequently the difficulty in articulation, phonation, and deglutition special to bulbar Paralysis does not occur.

Dr. Moxon has kindly permitted the following account of the above mentioned case to be published, taken from the report made by Mr. E. C. Beale.

F. Q., æt. 35, Policeman, Clinical Ward 12. Admitted 30th January, 1878. Now No. 22, Philip Ward.

Family history good. Patient has always enjoyed good health himself only suffering occasionally from cough. He has lately been much exposed to cold and wet; has always been temperate. No history of rheumatism or Syphilis. *During six weeks before the attack came on Patient was standing for three hours longer than usual, viz., for eleven hours of the twenty-four instead of eight.*

About six weeks ago he felt a numbness and tingling in his right hand whilst on duty, the same sensations extending up his right arm, and to the left arm during the next few hours. The next morning his lower extremities were similarly affected, and he became unable to move his arms, and within forty-eight hours from the commencement of the attack he had completely lost power in the four extremities nor could he sit up in bed. Sensation was totally unaffected. Patient has never had any convulsions or spasmodic movements. Never any sickness, or impairment of vision, speech or deglutition. Complete control over the bladder and rectum, except at times when aperient medicine has been taken. Bowels very constipated.

Present condition.—Well nourished, but says that he

has lost flesh during his illness. Lung and heart sounds normal. No Ascites, Urine sp. gr. 1018. No Albumen or sugar. Patient can shrug his shoulders, and move his body slightly from side to side. Movements of head unimpaired. Muscles flaccid. No reflex action can be excited by tickling the sole of the foot. Sensation good in all parts.

Faradisation.—The muscles of the arms and legs do not respond in the slightest. The muscles of the neck Platysma, Sternomastoid, Trapezius, Levator Anguli Scapulæ, Rhomboids (Cervical nerves) respond freely.

Galvanisim.—Muscles of arms react feebly, none except the Peronei react in the leg.

Feb. 11th.—Breathing mainly diaphragmatic. Cannot cough with vigour. Galvanisim daily. Muscles wasting in both arms and legs as shown by measurement.

Feb. 15th.—Fæces constantly running away.

„ 18th.—No muscles respond either to galvanism or faradisation in either extremity.

Feb. 23rd.—Small slough formed on the left buttock.

„ 25th.—Slight movement in the muscles of the right thumb.

March 28th.—More power in the thumb and forefinger. Cough more forcible.

April 6.—Muscles treated with strong Faradic current. No reaction whatever observed. Bedsore has nearly healed.

April 19th.—Can move his arm much better. General health good.

Pathology.—That the above symptoms indicate an affection of the anterior Cornua can scarcely be denied. Thus, Dr. Wilks tells us in his work on "Diseases of the nervous system":—"If an injury or disease of the cord involve the anterior Cornua the motor root would be involved, which would produce not only a loss of function of the nerve, but an actual degeneration of fibres along its whole course, together with a corresponding atrophy of the muscles to which the nerve is distributed." Again, the resemblance, and almost identity of symptoms with those which occur in Infantile Paralysis would indicate a similar lesion in the large motor cells of the anterior Cornua. These cells may be regarded not only as the Nuclei of the anterior or motor nerves, but as presiding over the nutrition of the muscles, the trophic filaments passing along the anterior nerves in the same way as those presiding over the nutrition of the skin pass from the central and posterior regions of the grey matter of the cord along the posterior nerves. It is true that muscular wasting may occur in cerebral disease, but the immediate cause in that case is implication of these same motor cells by horizontal extension from the laterial column along which descending degenerative changes have extended.

Again, Duchenne states that loss of electric contractility in spinal affections is pathognomonic of lesion in the motor cells of the anterior Cornua. His words are, as translated, "Electric contractility is not diminished in any disease of the spinal cord except those in which the motor cells are changed or destroyed, as in acute spinal paralysis of the infant or of the adult."

It is therefore more than probable that the anterior Cornua are affected, and the absence of sensory paralysis, tremor, incondination, spasm or other symptoms indicating disease elsewhere render it probable that the affection is limited to these parts of the cord.

Is the disease functional or organic? The question may be answered by referring to Infantile Paralysis; the symptoms in the two cases are similar, the anterior Cornua must be involved in both, in both there is a tendency to recover which in a case of Infantile Paralysis recorded by Duchenne has occurred when the muscles have been atrophied and electric contractility lost for as much as four years. It seems unreasonable therefore that in Infantile Paralysis degeneration and atrophy of the large cells of the anterior Cornua should be acknowledged as the primary lesion, while in the above disease none should be believed to exist. It is true that there is no post-mortem evidence, but this is not to be wondered at, considering that the disease affects no vital parts, and involves no danger to life.

It will be observed that a bedsore formed on the buttock in the case mentioned above, whereas as a rule in Adult Paralysis no Eschars form on the Sacrum, and the appearance of *acute* bedsores, whether on the buttock as in Hemiplegia, or on the Sacrum as in Paraplegia is now known to be a bad sign, foretelling a fatal issue. When however a part is subjected to constant pressure, and to the irritation of urine and fæces, bedsores will occasionally form, notwithstanding the most careful nursing which a patient in Clinical Ward would be sure to have. They would not then necessarily forebode such a serious result. Acute bedsores again form from the second to the fourth day of the attack, and not as in this case after two months.

Diagnosis.—It has been already shown that the general motor paralysis, muscular wasting, and loss of electric contractility with retention of sensibility indicates a disease limited to the anterior Cornua, but it may be as well to point out how to distinguish other affections which might be confused with it.

In Paralysis due to Cerebral disease the muscular wasting, and loss of electric contractility only exist when descending degeneration has implicated the anterior Cornua, besides which symptoms exist referrible to Cerebral disease.

In Myelitis (Diffused Myelitis of Duchenne) due to Hæmatomyelia, softening, Pyæmia, Caries of the spine, cold, &c., there is sensory Paralysis, and loss of power over the bladder and Rectum, whilst if motor paralysis, muscular wasting, &c., co-exist, this would indicate implication of the anterior Cornua.

In chronic Meningitis the pain, Hypæsthesia, and spasmodic movements are characteristic, and though paralysis may follow gradually, extending over the limbs and body, this is caused by extension of the disease to the spinal cord.

In Diphtheritic paralysis sensation and motion are

usually simultaneously affected, the muscles do not waste, nor is their electric contractility lost, besides which there is the history of its beginning in the soft palate, the extreme slowness of the pulse and other indications of Diphtheria.

In Syphilitic disease of the spinal cord (tumour gummata, &c.). Dr. Moxon has shown that Peraplegia may be produced of a somewhat similar nature. In the above case however no history of Syphilis could be obtained.

In lead Paralysis the same general motor paralysis followed by wasting of the muscles may occur, but electro-contractility is only lost in certain muscles (Extensor muscles of forearm, and of the foot and leg) being retained in others (Flexor and Supinator muscles), but it would seem probable that the nerve trunks, or their nuclei of origin in the anterior Cornua are in some way implicated, as Dr. Bristowe suggests, on account of the wasting and motor Paralysis.

In Hysterical Paralysis electro-muscular sensibility is lost, electric contractility retained, there is usually sensory paralysis, and the muscles do not waste.

In General Paralysis of the Insane there is the mental affection.

In nerve Paralysis the same motor Paralysis, wasting, and loss of electro-contractility with retained sensation may exist in the muscles supplied by the nerve, but in the above case the affection being general is obviously due to a more central cause.

In infantile Paralysis the symptoms are similar in all respects, but the age at which it occurs (infancy) and the deformities which occur from non-development, should it be permanent, enable it to be recognised.

In Pseudohypertrophic Paralysis there is weakness at first without loss of electric contractility, followed by muscular enlargement, specially of the calves, whilst loss of electric contractility and complete motor Paralysis only occur late in the disease.

In Progressive Muscular Atrophy the atrophy precedes the weakness in the muscles, the electro-contractility is only lost late in the disease, and fibrillar vibrations may be evoked in the muscles by tapping or otherwise exciting them. The muscles waste one by one, and not *en masse*.

Lastly subacute general anterior spinal Paralysis (General Spinal Paralysis of Dr. Bristowe) is distinguished

1.—By the onset which is gradual, weakness being usually first felt in the Flexors of the foot upon the leg, then in the Flexors of the thigh upon the trunk, and then in the Extensor muscles, walking becomes difficult, and even partial movements in the lower extremity become gradually impossible. Their is no fever or pain, no sensation of numbness or tingling.

2.—Shortly afterwards electric contractility is impaired in the same progressive manner, first in the Flexors of the foot upon the leg, then in the Extensors, and lastly in the muscles of the thigh and Abdomen.

3.—The muscles after being paralysed waste "*en masse*," being as it were, mummified, but weeks or more often months pass before the patient is confined to his bed.

4.—The Paralysis remains limited to the lower extremities for a time (weeks, months, or perhaps years), and then the upper extremities are attacked, the Extensor muscles of the hand upon the forearm being first affected, then those of the hand, then the Flexor muscles of the hand upon the forearm, and lastly those passing from the arm to the Thorax, electro-contractility being gradually impaired, and the muscles wasting as in the lower extremity.

5.—Lastly the muscles of the trunk and face are involved in the same progressive manner.

6.—Less often the disease first affects the upper extremity, and then the lower extremity, and lastly the trunk and face.

7.—The lesion may extend to the Medulla Oblongata, and phonation, deglution, and respiration become difficult as in Bulbar Paralysis, and death may result from Asphyxia or Syncope.

8.—The disease may however be arrested, and the parts recover power, so that the complaint is not necessarily fatal.

9.—As in the acute variety sensation is unaffected, there is no loss of control over the bladder or Rectum, no rigidity, nor do eschars form on the Sacrum.

10,—The disease would seem analogous to Progressive Muscular Atrophy the motor functions of the nerve cells being primarily, and specially affected in the former disease, the trophic functions in the latter.

Causation.—The cause often cannot be ascertained, but in many cases, as often in Infantile Paralysis, cold and wet seem to be the main agents. Why in one case a special nerve (Musculospiral, Radial, Circumflex, &c.) should be picked out, while in another the spinal cord is affected, is unknown, this seeming to depend on individual predisposition. Excess of muscular energy, as a long march, *long standing*, was also found by Duchenne to be an occasional cause. It comes on between the ages of 18 and 45.

Prognosis.—Acute anterior spinal Paralysis, or Adult Spinal Paralysis according to Duchenne involves no danger to life, and the Prognosis is only serious on account of the danger that some of the wasted, and paralysed muscles may remain useless in after life. He in fact specially mentions the relative gravity of the Prognosis in the subacute form or General Spinal Paralysis because of the danger of that disease extending to the Medulla Oblongata, a danger which does not exist in the acute variety.

Treatment.—The periodical use of electricity to the affected muscles is the form of treatment recommended by Duchenne, and that usually adopted. Duchenne recommended the alternate use of the direct current, and of Faradisation, the former improving the circulation and nutrition of the nerve centre, while the

latter promotes the action of the paralysed muscles. If electro-contractility is completely lost, or if there is atrophy of the muscles the slowly interrupted galvanic current is most efficacious, and if the muscles improve Faradisation.

[We are indebted to Mr. Montagu Lubbock for the above.]

CASE OF SEVERE DYSTOCIA.

E. B., æt. 25; married; 4th confinement. Character of previous labours, tedious; forceps had been used in one previous confinement. The woman was in good health, and she had gone to full term. The extern was called about 11 a.m., he found the os nearly fully dilated, and the vertex presenting; pains strong and frequent; pulse full and regular. The membranes were ruptured, but the head made no advance and remained above the brim. This state of things continued for five hours, when Dr. Galabin and the Charity came down. The woman was now beginning to be irritable, and the pulse had gone up to 120, strong and regular; pains every two or three minutes, terribly strong, the uterus becoming of almost stony hardness, and scarcely felt relaxed in the intervals of the pains; the head, in the first position, was (lying) above the brim, and the severe pains did not appear to advance it at all. The transverse pelvic diameter was made out to be somewhat contracted, and the sacral promontory was easily reached, but the slight contraction was not sufficient to account for the dystocia. Barnes' forceps were then easily adjusted, and a very considerable amount of traction employed for some time, but without advancing the head in the slightest degree; the head was embraced tightly in the cervix, and the tremendous force of the uterus contracting, more than counterbalanced the traction of the forceps. The woman was then put under chloroform, in the hope that the anæsthetic would, in a certain degree, cause relaxation of the tetanic spasm of the uterus; the effect produced however was only slight. Version was then determined on, and while preparing the woman for the operation, it was noticed that the cervix was considerably lengthened out, the line of the internal os being distinctly visible through the abdominal walls 4 inches above the symphysis pubis. It was remarked that this is often the condition immediately preceding rupture of uterus, the rupture commencing at this line and spreading upwards towards the fundus. The head could scarcely be moved to the side, so that it was with much difficulty that a foot was seized and brought through the os. Combined bipolar version by Dr. Galabin and the Senior was then attempted, but the head could not be made to move up, it being tightly grasped by the lengthened out cervix. At this time the cord was felt to be feebly pulsating. Craniotomy was then suggested, and the perforator introduced in the mid parietal region. After a great deal of traction the head at last went up and the breech came through the os. The arms were brought down, but the after coming head would not come through, the perforator therefore had again to be used just behind the ear; the cranial bones appeared hard and unyielding, but the head was now delivered after gentle traction. The placenta soon followed and there was scarcely any hæmorrhage. The uterus was cleared of the clot and brain matter, and nothing in the way of a rent was discoverable by the touch. The labour was completed at 7 o'clock, the woman having been under chloroform an hour and a half. At 9 o'clock (p.m.) the pulse was quiet and strong, and the woman seemed to have recovered well. At 10.30. next morning she died, half an hour previously becoming suddenly worse, blue in the face and gasping for breath according to the nurse. No P.M. was allowed; mere external inspection showed abdomen much distended with gas, the uterus feeling normal through the abdominal walls.

G. MACKERN.

MEDICAL DEGREES.

No. I. OXFORD.

The number of Candidates for Medical degrees at the various Universities is no doubt increasing, and probably will do so still more; in certain cases however it is to be expected that the increase will be much checked by the necessity for residence, and by the long period over which the necessary course is extended. Hence the comparatively small number of Medical Graduates at Oxford and Cambridge. These two Universities make nearly corresponding demands upon the time of their candidates; the arrangements of the latter body will be discussed in a future number; at present it is intended merely to indicate with as little detail as possible the ordinary methods pursued to obtain the Oxford M.B. This is practically the only Medical degree to be acquired there, as there are no Surgical degrees corresponding to the M.C. of Cambridge, or to the B.S. or M.S. of London, and the M.D. follows the M.B. without further Examination at the end of three years upon payment of the required fee.

Two Examinations are necessary to obtain the degree of M.B. The First M.B. and the Second or Final M.B. Examinations. Every Candidate for the First M.B. must already be a B.A., or if he have not actually taken the degree must have passed all the Examinations required for it. It is not necessary to describe in detail the process of acquiring a B.A.; several Examinations have to be passed in Classics, Mathematics. &c., after Matriculation for which also an Examination is required varying in difficulty with the different Colleges, and finally an undergraduate may take his degree either as a Pass-man, in which case he will have to undergo several Examinations in certain subjects, Classics, Law, History, or Mathematics according to choice, only a certain number of these subjects being required. Or in case he should read for Honours he may again choose any one of the several "Schools." Thus Honours, and therefore the degree of B.A., may be obtained in Classics and Philosophy, or Mathematics, or Law, or History, or Theology, or Natural Science; the last is the one of most interest to the future M.B., for by choosing it the B.A. may be made a direct stepping-stone to the Medical degree. We will therefore suppose that the undergraduate has made up his mind

to read for Honours in the Natural Science School. He may choose as his subject either Biology, Chemistry or Physics almost as a matter of course, having made up his mind that he will take the M.B. Afterwards, he will choose either Biology or Chemistry as the two subjects bearing most closely upon his profession. In either case he will have to pass a preliminary Examination of no very great severity in Chemistry and Physics. If Biology is his choice he will work at Comparative Anatomy, Physiology and Histology more or less during his whole time at Oxford, and exclusively after he has passed the earlier Examinations. If he has done no work of the kind before coming to Oxford, he will find that the maximum time allowed of four years is not at all too much to get high Honours. The degree may however be obtained in three years.

One year after taking his B.A., he will be able to pass the First M.B. Examination held every year in December. For this he will be examined in Anatomy, Physiology, &c., including a certain amount of Comparative Anatomy, also in Chemistry, Physics and Botany. Two years after passing the First M.B. he will be eligible as a Candidate for the Final M.B., when he will be examined in Medicine, Surgery, Midwifery, Forensic Medicine, Hygiene and Materia Medica. Hence the whole course from the time of Matriculation until the time of taking the M.B. degree extends over from, six to seven years. Of this time however only the first three need be spent at Oxford, *i.e.* residence is only required for that time, though it is desirable if not necessary to reside until the B.A. is taken. After that the time is usually spent at the Hospitals in London or elsewhere, and other work for the College of Surgeons, &c., is carried on at the same time.

As regards residence in Oxford, this may be managed either by entering a College, which is the more expensive but perhaps the better plan, or by living in lodgings; and it may be estimated that about half of each year will be spent in Oxford, although at any rate during the latter part of the course it will be desirable to be in residence considerably more to make use of the Museum. The process of obtaining the M.B. appears rather complicated at first sight, and many of the details can only be settled after Matriculation. The complexity is however chiefly due to the large amount of choice left to each man as to the particular course he will pursue, and disappears as soon as that course is settled.

In stricture of the œsophagus beware of feeding patients exclusively upon animal food, as scurvy may result. Lemon juice should be given to supply the place of vegetables.

Sickness from cod liver oil is often much relieved by taking a pinch of salt before and after the dose.

Correspondence.

TO THE EDITOR OF THE GUY'S HOSPITAL GAZETTE.

Dear Sir,

I hope you will spare me a little space in your valuable journal to make a few remarks on "Work in the Museums."

I enter the Anatomical Museum at 10.15. a.m. and am soon deeply absorbed in my Gray. Before five minutes have elapsed, my ears are struck with the words "Marshalls," "Bludgeons," "Standards," &c. uttered in a loud voice. I look up and find two gentlemen have seated themselves close to me and are busily engaged in discussing the Meeting held in Hyde Park last Sunday. Finding they mean to pursue their discussion "to the bitter end" I put my Gray under my arm and march off to the Bone-Museum in hopes of finding a quiet corner there behind the wax models. I find a space and seat myself in it. In three minutes, two students come there also, when one proceeds to favour his friend with a caricature (in propriâ personâ) of the voice and manner of a highly respected gentleman well known to all first and second year's men. I observe with curiosity that they have only got one book between them, and think with satisfaction that one will perhaps depart, shortly. I am worse than dissappointed, when one opens the book and begins *to read to the other.*

I get up to try the "Anatomical" again and sit down there once more. Soon, one gentleman gives another a graphic account of the Goring Divorce Case, and when that is over, as if everything were against me an engine on the Brighton line lets off steam for fifteen minutes without stopping, and after an interval of ten seconds does it again for ten minutes and again with twelve seconds interval for another ten minutes. At last that being over I breathe freely, when to my disgust a cat begins to miaow in the most tantalizing manner on the roof of the museum. *By the miaowing of that cat I should have judged it had lost* at least twenty-five kittens, but it soon became evident that the brute could not get down from the roof. How I longed to be able to catch that cat, and pictured to myself the grim satisfaction with which I would hand it over to Baker, and see—well!—the last of it at the Physiology Lecture.

I rush off in despair to my lunch, vowing to punish *that,* if I could nothing else.

Yours truly,
JANUS.

SOME WORDS OF WISDOM.

You may have a cavity in the lung without getting cavernous breathing when

1.—The cavity is full of fluid.
2.—The cavity is large but very small tubes lead to it.

Disease of the brain is denoted by

1.—Constant pain. 2.—Sickness. 3.—Optic Neuritis.

The sight may be affected by disease of any part of the brain giving deafness, or disease of the ear, and any cerebral symptom may supervene.

Bronchitic sounds at the apex of the lungs should always lead one to suspect Phthisis.

The heart may call out in two ways, by

1.—Breathlessness. 2.—Angina Pectoris.

The aim of Therapeutics in heart disease is to improve the blood, thus lessening the tension against which the heart has to act, it being certain that the interchange between the blood and tissues goes on more easily when the former is in a good condition. Hence Ol. Morrhuæ and the preparations of iron may be very useful.

GUY'S HOSPITAL GAZETTE

MAY, 1878.

IN the midst of all the discussions upon medical reform which from time to time agitate the minds of the profession, the subject of the student's preliminary education seems hardly to be treated with the importance which it deserves. All schemes of medical education seem to aim rather at a high-pressure standard of scientific attainments, based upon a process of cram, compressed into four or five years, than at a broad, well founded course of training depending upon the principle of the gradual development of mental power generally, rather than in limited directions. When an athlete is undergoing preparation—say for a boat race,—but a small part of his time is spent at the oar. His proficiency is rather by a general course of exercise in the shape of walking, running, or what not, to improve his physical powers as a whole. But turning to the mental arena, we see too many people adopt a very different mode of reasoning, and guided by the narrowest utilitarianism, insisting upon the rejection of all branches of study which do not, to their limited vision, send a direct means to an end. Latin, Greek, Literæ Humaniores, are effete, useless, antiquated, and following their arguments to their logical conclusion, we should probably soon be introduced to Academical dons who have proudly graduated in Book keeping and Mental Arithmetic.

The medical practitioner in embryo must be forced through an absurdly high course of scientific work in Chemistry, Physiology, and the like, if he is destined for a higher academical position than his fellow, but no care whatever is taken that he has received any mental culture to prepare his mind for this exotic seed, the fruit of which turns out too often a weakly, hideous monstrosity, The preliminary examinations and even the University matriculations fail ridiculously as tests of that culture to which Matthew Arnold would apply the name, and which after all is the truest expression of a mind filled to grasp the great truths of a profession like ours. If the profession is to be reformed, let us by all means begin at the roots of the tree, and send as good material to the medical schools as possible. Raise the level of the preliminaries from that of the Cambridge Junior Middle Class (for assuredly little difference exists in their calibre) to something like reasonable evidence that the would-be student has received, and profited by, a liberal education. To do this, the standard in all the subjects should be much raised. In Euclid, (perhaps the study of all others best fitted for bringing out the logical side of a man's character) more books should be given. In Algebra we might summon up courage to advance beyond simple equations. Again surely, the mental standard of the profession would be raised if its members gave some evidence of a little more clinical knowledge than a translation from Cæsar indicates. Greek also should be compulsory. Modern languages might be optional. However useful, as studied by nine out of ten men, they are but very feeble engines of mental culture. English Literature surely ought to be a subject of examination. The refining and cultivating influence of a study of the beauties of Shakespeare or Milton can scarcely be over estimated. And again, although of less importance perhaps, would it be too much to make the elements of Drawing at least an optional subject. Apart from the elegance and refinement of thought that a study of art puts in the way of those who care to avail themselves of it, in this way acting as a counterpoise to the habits of mind induced by scientific work, the utilitarian argument may be strongly put forward in its favour. Every student knows how valuable to him in every stage of his career is the power of delineating what interests him. One at least of recent Introductory Lecturers has urged a study of art as a preliminary to medical work. Many of the foregoing propositions may sound Utopian, but none of them go beyond what is everywhere admitted as the standard of a liberal education, and which surely is worth attaining in a profession coming more intimately into communication with the public than any other, and the members of which certainly ought to be able to take their true place, as is now too seldom the case, in the society of cultured men.

Atonic dyspepsia, with a tendency to constipation, is best treated by mild laxatives, and alkalies combined with gentian.

INTESTINAL OBSTRUCTION.

BY G. H. RUSSELL.

THE PRIZE PAPER OF THE PHYSICAL SOCIETY.

By intestinal obstruction we mean constipation from some mechanical obstruction to the onward flow of the intestinal contents—organic constipation, i.e., constipation with an organic lesion underlying it.

To the constipation are often added other symptoms vomiting, nervous prostration, suppression of urine, &c. The mechanical cause varies almost infinitely. We usually arrange such cases in 5 groups—impaction, stricture, compression, strangulation and intussusception.

The last forms a thing by itself, the others roughly speaking advance in symptoms, thus in impaction the nerve symptoms become important, in strangulation they become all important.

Intestinal obstruction is by no means unfrequent—Dr. Brinton found only 1 in 280 P.M's., but Dr. H. Fagge about 1 in 70. I myself in looking through about 3400 P.M's. have found 52, which is rather over 1 in 65.

Hence 1½ per cent. P.M's. are of fatal intestinal obstruction. With regard to the years, the most have been 5, 8, 6, 5, 9. 8, 5, 6, or 52 in 8 years = 6½ a year.

Hence if you say half a dozen poople a year die in the hospital of intestinal obstruction you will be within the mark.

Please remember, however, that you get a great many cases of pseudo intestinal obstruction which you have to diagnose, and that many cases even of organic obstruction are cured, or so relieved as to go out.

Furthermore men with stricture of the rectum don't usually die with obstruction, or if they do, are patched up, sent out and die out of the hospital. There were in 13 years 36 cases of stricture of the rectum—12 obstruction, and 12 stricture rectum cases, and 6 deaths yearly.

IMPACTION.

Complete obstruction may be caused by the impaction of a gall stone, of a mass of indigestible food, or of hard masses of fæces.

Obstruction from gall stones is very rare. We have had no fatal case at Guy's, six are on record in the *Pathological Transactions*.

The gall stone is always large; it always ulcerates its way from the gall bladder into the duodenum, and the passing along the small intestine causes perhaps partial and finally complete obstruction and death; or it may be discharged per anum in which case it has probably ulcerated its way from the gall bladder into the colon.

We should expect then no jaundice since the ducts are not involved, and we get none. But there are usually premonitory symptoms pain, &c., then intermittent attacks of constipation, and then the final attack of complete obstruction, incessant vomiting, and rapid sinking. This is the most rapid and rapidly fatal of all forms of obstruction, the average time before death being 5 days. It happens only in people advanced in years, and chiefly in women. Case under Dr. Pye Smith (in p.p.)

Tms. S. 69. Three months unwell. A fortnight of pain in the R. Hypo-chondrium and feverishness. Then irregularity bowels.

The fatal illness began on April 25th with sickness and slight pain, on the 3rd and 4th days her bowels were confined and she vomited incessantly, bringing up about 1¼ gallons of greenish fluid. On the 5th day the vomit was fæcal and she was obviously sinking, on the 6th day she died comatose.

P.M. Gall stone 4½ by 2½ inches tightly impacted in the jejunum. There was an ulcerated communication between the almost absorbed gall bladder and the duodenum, protected externally by strong fibrous adhesions.

The noteworthy points are the sex, the age, the long premonitory symptoms and the rapidly fatal character, with the incessant vomiting of the last attack. In the other five cases in the *Pathological Transactions*, the ages were 69, 66, 58, 46, 27. Four were in women; one in a man.

But the stone may be passed per anum, as in two cases recorded by Dr. Fagge (Guy's Reports, 1869). In the first case the stone was 2¼ by 1½ inches: in the second 2 by 12 inches. The one in a man, the other in a woman: the man being 64, the woman 56: the one caused 4, the other 7 days complete obstruction. They were passed only after severe pain.

It is very rare for indigestible matters such as fruit skins or fruit stones to cause total obstruction. Only one such case on record, is that of an idiot boy who died after 15 days of obstruction caused by a ball about the size of a hen's egg, composed of cocoa nut fibres tightly interlaced.

More usually such matters cause temporary obstruction, or by getting into the cæcal appendix, or a diverticulum of the ileum, cause inflammation (case 39), or even ulceration, perforation and death.

Dr. Wilks denies that scybala ever cause complete and fatal obstruction. We have three cases on record at Guy's, one had cancer of the ovaries; the others seem to have died of obstruction. All three cases (cases 1 and 2 and one in Dr. H. Fagge's paper) were in females and lasted 30 days, 23 days, 14 days. There is no pain, no sickness, but complete constipation and gradual failing of the vital powers. In two of the cases the nature of the trouble was surmised; the other was mistaken for intussusception in consequence of there being a shifting tumour which was fæcal.

[Dr. Duchaussoy says the usual places for scybala to be impacted are the cœcum, the sigmoid flexure, and the anal dilatation of the rectum. In the three cases above (1) the second curve of the sigmoid flexure had contracted on a hard mass of fæces; (2) there were scybala in the rectum "which could not be expelled by forcible means (3); the rectum was stuffed full of hard fæcal masses."]

STRICTURES.

Causation:—Strictures are either simple, syphilitic or cancerous. Simple strictures are caused by the contraction of the cicatrix of an ulcer or are congenital.

The cancerous strictures are by far the most common, thus from 1854 to 1869 there were 4 simple, 0 syphilitic, 18 cancerous. During the last eight years, 9 simple, 2 syphilitic, 16 cancerous, which proved fatal.

Simple strictures:—An ulcer in order to cause stricture must be large, and have a tendency to heal and consequently to contract.

The chief ulcers (excluding syphilis) are typhoid, tubercular, dysenteric, of intussusception, and simple.

Typhoid ulcers never cause stricture, they are too small.

Tubercular ulcers are large, but shallow and have no tendency to thickening and very little to healing. Hence though between 20 and 30 people a year die with extensive tubercular ulceration, I have not been able to find one case of stricture. Dr. Moxon has seen two. Tubercular ulcers more often cause slight peritonitis, and consequent matting together of the intestines, and may so cause obstruction (case 33).

The ulcers of dysentery and intussusception more frequently contract and cause stricture. But in more than half the cases, the stricture is due to the contraction of a simple ulcer. Nor is this surprising. The frequency of simple extensive ulceration of the rectum has not been sufficiently pointed out. One meets with many such cases in old people or those long bed-ridden, as the post-mortem reports shew.

Congenital strictures are always (!) confined to the rectum. In one fatal case the stricture was simply a valve of mucous membrane; in one non-fatal case (in Clinical, 1877) there had

been a similar valve which Mr. Colley had divided by a ligature so saving the girl's life.

The simple strictures have during the last eight years been as follows—Three simple ulcerations of the rectum (case 4, 5, 6) and one of the sigmoid; a fourth was caused by the contraction of an ulcer of the rectum (case 3), after an attack of dysentery in India (case 9); a sixth by the contraction of a ring of connective tissue round the ilium which was the scar of an old intussusception (case 8); the seventh by a projecting curtain of m.m. one inch from the anus, the remains of imperforate anus; the eighth by an exaggeration of the natural coats of the rectum which formed rings and valves (case 10) doubtfully syphilitic; the 9th was wholly exceptional, thus—There had been extensive ulceration of the rectum, and as a result an abscess formed in the fat around the rectum. The abscess empted itself, but the abscess cavity, thickening and contracting, strictured the rectum (case 7).

Syphilitic stricture:—Fatal syphilitic strictures are very rare. We have only two such cases (cases 13 and 14) and in both the fatal result is distinctly traceable to the treatment. Yet non-fatal cases are very common. Thus in 1870 there there were 9 syphilitic, 6 cancerous, and 8 doubtful strictures of the rectum. In 1871-8 there were 8 syphilitic, 7 cancerous, and 8 doubtful, in the surgical wards. (see appendix 3.)

Syphilitic strictures occur only in the rectum.

They occur almost solely in women. Thus of the 8 cases in 1871-8, 7 were in women. They are often complicated with recto-vaginal fistula, as in the two fatal cases.

Cancerous strictures are very common in all parts of the large intestine, but there is no case on record at Guy's where a cancerous stricture existed in the small intestine alone. With regard to any statistics about the *position* of cancerous strictures it must be remembered that while on the one hand a patient with cancer of the colon would be sure to die in the hospital, and would therefore be reckoned among the fatal cases; on the other hand many, if not most, patients with cancerous stricture of the rectum go out of the hospital to die (just as patients with syphilitic stricture), and are therefore *not* reckoned among the fatal cases.

Dr. Brinton said that of every 100 cancerous strictures 40 were in the cæcum and colon, 30 in the sigmoid, and 30 in the rectum. From 1854 to 1868 there were 18 cancerous strictures which proved fatal, viz. 7 in the cæcum and colon, 5 in the sigmoid, 5 in the rectum, and one in two places. From 1868 to 1876 there have been 16 fatal cancer strictures, viz. 4 in the rectum, 5 in the sigmoid, 2 in the colon, and 5 complicated. It will be seen that Dr. Fagge's figures exactly coincide with those of Dr. Brinton thus—

DR. BRINTON.	DR. FAGGE, 1854 to 68	1868 to 76.
COLON, &c., 40	7 + [6=42]	2
SIGMOID 30	5 + [6=30]	5
RECTUM 30	5 + [6=30]	4
MIXED	1	5
	18	16

My own figures are somewhat different. I have noticed on looking through the P.M. reports many cases where the hepatic flexure of the colon has been invaded by cancer, and also the duodenum, but as a rule in the former case there was diarrhœa, in the latter vomiting, or perforation of an artery, &c., &c., but seldom complete destruction (*e.g.*, see P.M. reports 314 in 1869, 162 in 1872, 110 in 1876, &c).

The complicated cases are as follows:—

1.—Cancer of the cæcum and ileum (Dr. Hilton Fagge).

2.—Cancer of jejunum, ileum and rectum.

3.—Cancer and intussusception of the rectum.

4.—Cancer of the rectum and ileum, &c.

5.—Large mass of cancer secondary to cancer of the testis pressing on the colon.

6.—Ovarian cancer invading colon.

It will thus be seen that in 34 cases the disease was in only three cases in more places than one (for cancerous strictures see cases 15 to 30).

It may here be remarked—

1.—That cancer of the omentum, mesentery, iliac, or lumbar glands very rarely invades the intestine so as to cause obstruction but usually causes ascites, &c. (see P.M. reports 146 in 1876, 77 in 1875, &c). We have however one case of stricture of the colon (case 25) where the cancer began in the mesocolon and glands.

2.—That secondary cancer of the intestine is very rare. I have never met a case. It is strange sometimes how it avoids the intestine. Thus in one case there was, secondary to cancer of the breast, cancer of the pleura, liver, spleen, both kidneys and spleen, of the spine, and of the ribs, but not of intestines.

3.—That a growth even of the intestine may cause death in some way other than obstruction (as in 296 in 1875, where a sarcoma of the sigmoid and rectum pressed on the ureters, and veins, causing dropsy, dysuria, &c.

4.—That I have not included deaths from imperforate anus, or from operations for it (such as 517 in 1875). These are not unfrequent.

5.—That strictures of the rectum are generally complicated with recto-vesical or recto-vaginal fistula, or fistula in ano, &c. Thus of the 23 non-fatal strictures of the rectum in 1870, 14 were uncomplicated, and 9 complicated, 4 with piles, 1 with recto-vaginal fistula, and 4 with fistula in ano. Complications are more common in fatal cases.

6.—That next to the rectum (and stomach?) the most common seat of abdominal cancer is the liver, with the colon and duodenum immediately adjacent: and that the symptoms may closely resemble those of cancer of the pylorus (see P.M. reports 383 and 423 in 1874; also 116 and 125 in 1876.)

The presence of a stricture leads to great dilatation of the bowel above, with thickening of its coats and accumulation of fæces in it; while the bowel below is small, emptied, and it may be atrophied.

Hence in a P.M. on a case of stricture of the rectum or sigmoid you would find the colon filling the greater part of the abdomen, being enormously distended with gas and fæces; its coats thick perhaps like wash leather (case 23): the peritoneal coat being thickened by chronic inflammation and the muscular coat perhaps $\frac{1}{10}$ of an inch thick.

This gradual distension thickens the peritoneal coat (case 11) but great and sudden distension finds the peritoneal coat brittle and breaks and everts it. The m.m. may then protrude and either hold on safely, or a pin-hole in it cause fæcal extravasation (case 48). The peritoneal coat then is brittle, but the m.m. being elastic often stretches so as to form herniæ or diverticula.

It is strange that when the large intestine is greatly distended the strain is felt most in the cæcum, which may be purple and more than a foot in circumference (case 20). It often bursts causing fæcal extravasation and death (cases 20 and 24).

CLINICAL HISTORY OF STRICTURES.

They usually begin with pain and irregularity of bowels. To this succeeds complete obstruction, with or without pain; with much abdominal distension, visible peristalsis, borborymi. After a time nausea, vomiting, hic-cough come, on and the patient dies.

The progress of the disease when let alone is chronic; the patient lying in bed with complete obstruction for two or even three weeks without urgent symptoms, and this after months of incomplete obstruction. Between simple and syphilitic strictures it is generally impossible to diagnose, but between them and cancerous it is usually possible.

1.—Syphilitic strictures occur in young people, women. Such cases have a long history, 5, 6, or even 8 (case 13) years: they are sometimes better, sometimes worse. They are always in the rectum.

Thus one woman who had had syphilis ten years before, had a stricture for six years. This caused a discharge per anum, with tape like motions. She was in the hospital two or three times, and each time got much relieved, but when she got out and her health became bad again, her stricture became troublesome.

If then a young woman comes in with stricture of the rectum, which she has had some years, and above all which is sometimes better and sometimes worse, you know that the stricture is not cancerous.

2.—Cancerous strictures never fluctuate but advance steadily and progressively to a fatal termination. They occur chiefly in elderly men—average age about 50 (52). I have never known the history to be longer than 2 years It is of this kind. Æt. 50. Two years ago began to have slight pain in passing fæces. During the past year has suffered much from diarrhœa. When this ceased we noticed his motions were tape like and small; for the last month or two they have been covered with slimy matter and the patient has passed blood with them. The pain has been great. The patient has wasted much. Ten days ago complete obstruction came on.

On admission—Patient then anxious looking; bowels confined; abdomen much distended; urine abundant; examination per rectum shews rugged hard stricture.

The patient lay in bed ten days with complete obstruction, much abdominal distension, fæcal vomiting, and then died prostrated.

As to determining the seat of the stricture—if it be anywhere in the rectum you can feel it with the finger or by introducing the whole hand when the patient is under chloroform. Don't be content with examining with tube of an injecting syringe (case 26).

If not in the rectum you may have three guides—injections, tumours, distended intestine with visible peristalsis.

Seventy-five per cent. of strictures are in the rectum, sigmoid, or descending colon, &c., any cancerous tumour in such cases would be to the left of the median line. In cancer of the colon you can generally make out such a tumour.

Please note that a soft fluctuating tumour (case 24) in the R. iliac fossa simply means a greatly distended cæcum, and is not incompatible with a stricture in any part of the colon.

The quantity of any fluid which can be easily injected per rectum will often if the stricture be low down guide you to a correct conclusion as to its seat. Thus in cancer recti low down nothing would be retained in the rectum, 1½ to 2 pints only could be retained, you would think (especially if you could feel no tumour per rectum or on the abdominal palpation) of the sigmoid as the seat of disease (case 23).

One would expect that the dilatation of the intestine above the stricture would be visible; and so very often it is. Hence you often have it stated in reports that the outline of the colon is clear, that there is much visible peristalsis of this evident colon, and lastly that you can hear gurglings. This indication often leads one astray, for in compression, &c., of the small intestine the distended coils above are often so dilated and placed transversely as exactly to simulate a distended transverse colon (cases 39 and 41).

[If on looking at a man's abdomen you see a coil of intestine visibly contracting you may be quite sure there is a stricture somewhere in the intestinal tract, Dr. Wilks.] (See case 23.)

[In one case of Dr. Hilton Fagge's the patient herself had noticed the gurglings for two months, but the stricture had been impervious only a week.]

To sum up then—All syphilitic strictures are in the rectum and you ought to be able to feel them.

In cancerous strictures the history is tolerably characteristic. If with this history you can feel a stricture per rectum you say there is cancer there and probably there only; if you cannot feel a stricture per rectum nor in the abdomen, and if you can inject Oiss. to Oij. and no more, the stricture is probably in the sigmoid; if you feel a tumour in the abdomen to the left of the median line with visible peristalsis and gurglings the stricture is probably in the colon.

What are the terminations of stricture cases if let alone? The result of an impervious stricture is of course death. But the mode of death varies.

Of simple strictures three were left alone.

1.—The intestine burst (case 3).
2.—Died of peritonitis after punctures to relieve flatus (case 6).
3.—Pyœmia (case 9).

Of cancerous strictures 3 were let alone.

1.—Sigmoid—Perforation—Sudden death (case 19).
2.—Sigmoid—Perforation „ „ (case 20).
3.—Sigmoid—Bursting of cæcum „ (case 21).
4.—Sigmoid—Pleuro-pneumonia (case 23).
5.—Colon—Bursting of cæcum „ „ (case 24).
6.—Exhaustion—7 and 8 exhaustion.

[All cases of cancer recti were fatal after colotomy].

Hence in your prognosis don't forget the probability of the death being sudden, especially if the stricture be in the sigmoid.

COMPRESSION.

Under this term we include those cases where the bowel is pressed upon by some body outside, or where it is dragged out of its place by adhesions, or where a coil is twisted on its own axis (volvulus).

COMPRESSION AGENTS.

1.—Ovarian cancer (case 29).
2.—Mass of cancer secondary to cancer testis (case 28).
3.—Retroversion of the uterus (not fatal, one under Mr. Bryant in 1873; another under Mr. Howse in 1875).
4.—Tumour of the vertebral column pressing on intestine.

The causes of contractions, bursts, &c., may be—

1.—Matting together of coils of intestine as a result of tubercular ulceration (case 3).
2.—Matting together of coils of intestine from simple peritonitis? (case 33).
3—Intestine contracted by its mesentery contracting after tabes mesenterica (case 35). (Case 50 in Dr. H. Fagge's paper.)
4.—Loop of intestine hanging down in the pelvis (case 84).
5.—Same as three "from old disease of glands" (48 and 49 in Dr. H. Fagge's paper).
6.—Peritoneal cancer causing adhesion of coils of ileum (Dr. H. Fagge's 47).
7.—Ileum adherent to self and abdominal wall from cancer (46).
8.—Ileum fastened to pelvis from old peritonitis.
9.—Strangulation of jejunum from adhesion after peritonitis from external injury (44).

COMPRESSION (CONTRACTIONS), VOLVULI.

When the intestine is pressed on by some body outside, or by some coils being matted together we speak of *compression*.

When a coil of intestine makes a sharp turn, or is twisted on its own axis we speak of *volvulus*.

Contractions, compression may be caused

A.—By some external pressure.
1.—That of an ovarian tumour (29).
2.—That of a mass of cancer sec. to cancer testis (28).
3.—That of a retoverted uterus (not fatal. One case under Mr. Bryant in 1873; one under Mr. Howse in 1875).
4.—That of a tumour on the vertebral column.

B.—By matting together of coils of the intestine by the lymph of peritonitis which may be
1.—Simple and acute? (33).
2.—Simple and chronic (42).
3.—Caused by tubercular ulceration (31).
4.—Caused by cancer of the peritoneum (47).
5.—Caused by external injury (44).

C.—By adhesions to other parts
1.—To abdominal wall from cancer (47).

2.—To cage of plevis by old peritonitic adhesions (40).
3.—To the spine (42).
D.—By contractions of the mesentery
1.—As a result of tabes mesenterica (35).
2.—From old gland disease (48 and 49).
E.—Simple displacement ? ? ?
1.—Loop hanging down in pelvis (34).

For volvuli, see case 32 and in Dr. H. Fagge's paper.

Compression and volvulus occur almost solely in the small intestine.

They are often mixed up, there being both compression and volvulus as in case 31.

Usually compression is chronic and without very acute symptoms so resembling stricture of the large intestine (hence the term stricture of the small intestine).

But volvuli in their clinical course often approach closely to the symptoms of strangulation.

Clinical symptoms—

The contractions differ greatly from the volvuli clinically.

Compression—

The contractions are in the small intestine, what strictures are in the large—and like them are marked by chronicity and the absence of severe symptoms.

The onset is not sudden, indeed it is often preceded by partial obstruction, extending perhaps over a period of 2, 3, or 4 years. This is accompanied by attacks of severe abdomnial pain, lasting a few minutes at a time.

When it comes on the abdomen is not much distended; the region of the colon not prominent; nothing is felt per rectum; no blood or slime per rectum; no tumour to be felt; during the paroxysms of pain, you see the bowel moving and hear gurgling; the patient vomits a good deal, and the vomit may be stercoraceous.

No severe collapse; no suppression of urine, the patient gradually sinking from exhaustion. The obstruction may be partial to the last.

Please note that the movements of the coils of bowel are usually visible. This denotes that such coils have their muscular fibres hypertrophied, and hence as Dr. H. Fagge has pointed out you get such visible peristalsis only in chronic obstruction, cases *i.e.*, in strictures of the large and contractions of the small intestine. The average age (from eleven cases) of patients with this form of obstruction is 30 years.

Terminations:—

The intestine never breaks, the patient dying from exhaustion or peritonitis, if he dies at all. But cases where the diagnosis is pretty clear, may be greatly benefited by treatment, or even restored to tolerable health, and this too when the patient was apparently in extremis. Hence the prognosis though cautious should be more hopeful than that in strictures of the large intestine.

The cases of volvulus have clinically but little in common except that the symptoms are markedly those of obstruction of the small intestine, vomiting being early and severe.

To be continued.

SURGERY AND MEDICINE IN 1525. WORKS PRINTED IN SOUTHWARK.

By W. RENDLE.

(continued.)

It will be difficult to see how these ancient learned men came to the dogmatic conclusions as to signs of disease which it appears they adopted. It was in fact yet the time when the word of a "Maister" was unquestioned, and the book of nature was not often read independently of the teacher's authority; however such as it is, "Guy's Gazette" is quite welcome to these interesting notes. I send this time little else than the dicta as to the urine. It is headed:

"The knowlege of ye dyversytees and colours of all maner of urynes through the whiche the physyins mynystre all maner of medycynes to the utyll and profytable helthe of man."

"Avicenna recordeth in the first part of his 4th book whereas he writeth that it is not possible for to ease nor help no manner of person without natural knowledge of the disease or infirmity of man. So many noble doctors say that it is perfectly known by the sight of the urine and the sour complexion of the man"—to proceed, "when the urine is red and thick, then the patient in 'seke body' is hot and full of blood, his complexion is named sanguine; when the urine is red and thin the sick body is hot and dry, his complexion is cholerick, and commonly his diseases come out of the gall. This person is soon vexed into anger, and he getteth commonly the 'yelowe jaundys'—urine white and thick, the sick body is cold and moist of nature, he is phlegmatick, and his disease cometh of divers watery humours. This man is commonly gladly alone—

White and thin—the body is cold and dry by nature and is named melancholic, he hath in him heavy blood of the nature of earth, and he is pale of colour.

When the urine is divided into four parts, the first is the circle upon the uppermost ring, and signifies 'grete payne in the heed;' second part is the next under the circle, and signifies disease in the breast and lungs; third part is the 'myddest' and betokeneth disease in the stomach, liver and melt; fourth part is the bottom of the urine, and betokeneth disease in the 'kydnes, in ye guttes, bladder, and matryce or moder'—finding any of these you shall know the disease of the person, it should be seen warm or it will wax thick, and then it ought to be 'agayne warmed to have his natural colours'—urines are divided into 20 parts or more; white and clear and subtle as water; white and thick as milk, like milk new 'molken,' like ginger or a camel's hide; these betoken an evil stomach without 'dysgestion.'

Urine quite yellow like a ripe apple betokeneth 'a parfecte dysgestion.' Black urine betokens fevers, and is not deadly when he maketh much at once. Urine black which hath been before white, and when the sick body feels pain in his left side, that betokens stoppage in the 'mylte;' red urine coming to lead colour, when there hang small grains about the circle signifies disease in the 'longues' named peripleumonia, and also an impostume named pleuresis. The urine of a young child of green colour signifies that cramp is coming of cold, as Avicenna testifieth in the second part of his first book; when green of one who hath pain in his stomach, and when 'ye se a substance lyke yest laynge in the bothom of this uryne sygnyfyeth that the persone is impoysoned; when the urine is sharp and biting in the issuing it betokens disease in the bladder 'or the bladder hath taken colde;' white or pale urine where white sand cometh signifies stone in the bladder; when red sand, it signifies stone in the kydneys.

Pale urine very stinking and very little thereof made 'is dedly.' White or pale urine, with much scum hanging about the circle betokens a moist head and many winds in the belly; many little pebbles or bells about the circle is bad. While troubled urine like the urine of an ass long time continuing signifies great pain in the head;

little and that like milk betokens 'gowte;' white urine which is subtle and thin like water betokens, as Egidius writes in his book of urine, the watery sickness named dropsy; one kind of urine signifies pain in the 'hynder parte of the heed,' and then in the forehead, and then in right side of the head. 'All this for named indycyalles of urynes is onely the understandynge and opynyons of ye wordy (worthy) and experte medycynes and maysters as Avicenna. Isaac Egidius dooth tesyfye with many other dyvers actours whiche have gretly practised for the prosperyte helth and welfare of man where to they have done grete dylygens.'

A very elaborate index is supplied. If only the index could be understood, it would guide us to a great treatment of disease; it tells us of remedies by the score good 'against' this and that and the other. The Author says of it that it is a table very 'utyll and profytable from them that desyre to fynde quyckely and remedy agaynst all maner of dyseases, and they be marked by the letters of the A B C in every chaptre,' that is, as he means it, that you shall find it very easily. I note these: 'To cleanse the stomach and to comfort digestion against pain of the heart; against cardiac passion; for the web in the eyen (eyes); against palsy, to flee lyes (lice not lies) on the heed, to breke the stone for lithargy or forgetfulness, for memory, for lunatyke people to recover the mind, to white the face, for hot causes, for botches, for coleric humours, against running sores, against lechery, and to increase it where deficient, a good salve for old sores, against tremble of the body, and the stinging of honey bees, a mixture for them that are fearful and something 'to make folke mery,' how to decide by rule laid down whether a seke parsone shal dye or not, and the like.

At the end is an ornamented page, with a tree and an Adam and Eve clothed as in some pictures of Robinson Crusoe in hair skins: and under these words: 'Imprentyd at London in Southwarke by me Peter Treveris dwellynge in the sygne of the wodows. In the yere of our Lorde God MDXXVI, the xxvii day of July.'

GUY'S GLEE CLUB.

On Friday evening any one standing just within the portals of the Medical Building from 6.30 p.m. to 7 o'clock, would have seen the lame, the halt, and the blind, all hurrying in the same direction, the centre of attraction being the Out-Patient Rooms. Here owing to Dr. Steele's kindness, the large hall had been fitted with forms, so as to seat a large number of persons, whilst at the lower end a platform had been constructed for the performers. All patients who could walk, or were in any way fitted to be present, were brought, and the nurses, as many as could be spared came, a number of night nurses getting up to come, thereby forfeiting two hours sleep, so eager were they to enjoy the evening's performance. Occupying the first two or three rows were the Sisters of the various wards, forming a charming little frontispiece.

The Entertainment was a Concert got up by the Glee Club, who had gone to considerable expense in providing a Grand Piano for the occasion, buying music, &c., and to considerable trouble in rendering the evening thoroughly enjoyable. Printed programmes were handed round before commencing.

The first piece was the overture to "Zampa," by Herold, very ably executed by Mr. Cross, this was followed by Gounod's "Soldiers' Chorus," which though well sung, was a little out of time, evidently owing to some diffidence in the choir. Mr. Maylard sang a solo, with much taste, called "The Yeoman's Wedding Song," by Pointkowski; the next piece was a glee "The Three Chafers," we thought the solo part of this glee was not nearly strong enough, and moreover good time was not kept. When we have said this, we have perhaps found as much fault as it is possible to find, and we can confidently say that the rest of the very good programme was gone through in masterly style, and without a single hitch. "The Death of Nelson" was well rendered by Mr. Stanley Taylor, who has a well-cultivated voice. Mr. Cross performed, as another Pianoforte Solo, with brilliant finish, "Erin," by Jules Benedict. This was followed by a comic song, called "The Showman," by Henry Byron. Mr. Pinching, who sung this, came on the stage dressed in character, causing great mirth and laughter by his amusing and really humourous style, which was quite irresistible. He simply brought down the house, or rather Out-Patient room, and was compelled by vociferous encores to sing more verses. Messrs. Gardner and Taylor then very effectively sang a duet, called, "I heard a Voice," by Stephen Glover, which was listened to with deep silence, and met with hearty applause.

"Waken Lords and Ladies Gay," by Mendelssohn was then given, which concluded the first part of the programme. After an interval of ten minutes, Bishop's glee "Mynheer Van Dunck" commenced the second part of the programme.

Mr. Bates then sang in good style and with much spirit "The Warrior Bold," and was followed by a comic glee, "Dame Durden," which caused much amusement.

Mr. Cross next favoured the audience with "Blue Bells," a Pianoforte Solo by Kuhe, and although perhaps it was a little beyond the criticism of such an audience, his fine execution brought him hearty applause.

The next piece was an extravaganza duet by Herr Krookie and Signor Pinchianini; so the programme informed us. These two foreigners (?) bore a very close resemblance to Messrs. Crook and Pinching. We may confidently say that it was the very best piece of the evening, and was well worth going to hear and see.

Signor Pinchianini came on the stage, looking like a Troubadour, with cocked hat and feather, and scarlet cloak gracefully folded around him.

Herr Krookie played the piano.

Pinchianini began to sing in truly operatic style, what sounded like Italian, though it was quite possible to make out Sister Luko, Clinicalino, Corneliano, Charitino, Dr. Steeletto, &c. Then Herr Krookie, still playing the piano, sang plaintively, in a beautiful tenor voice, whilst Pinchianini seemed enchanted by the melodious strains, and presently broke forth rapturously, and the two went on with a duet which was very fine.

Pinchianini at length making passionate love to Krookie, advancing, retiring, hoping, despairing alternately, until finally being apparently repulsed, and thereby so affected that he fell down on the stage, apparently dead, amidst the loud laughter and cheers of the audience, who, in spite of all reluctance insisted upon an encore, which was acceded to.

Then came a Laughing Trio by Messrs. Crooke, Gardner and Taylor causing much merriment. "Sally in our Alley,"

was very ably rendered by Mr. Barnard, who has a well-trained and admirable tenor voice, and who sang with great taste and feeling.

Messrs. Barnard and Gardner sang the duet "Army and Navy," their two voices going very well together.

Two choruses "The Bells of St. Michael's Tower" by Knyvett, and "Sleep while the Soft Evening" by Bishop were the two last on the programme, and were well executed. Between these Mr. Pinching by special request, sang "The Exciseman," again giving us all a good laugh.

All standing then sung "God Save the Queen," upon the conclusion of which, Dr. Steele proposed a vote of thanks to the Guy's Glee Club, for their kindness in getting up the entertainment, which was carried by vociferous cheering. The patients then retired to their respective wards about 9.30 p.m., after a very enjoyable evening, expressions of great satisfaction being heard on all sides.

We can vouch for the good effect on the patients, for next morning there was not one, who had been to the Concert, who did not feel much improved in spirits, many aches and pains having vanished like magic.

On the whole we think it was a great success, and that much credit is due to the Glee Club for their great kindness, and we venture to hope, that, ere long, they will again favour us with a similar dose of really good physic.

REVIEW.

NEWTH'S MANUAL OF NECROSCOPY.

This very useful little Book supplies a well recognised want. Without in any way professing to write a pathological text book, the Author treats in a singularly able and lucid manner of those points which a student or practitioner requires to have at his finger ends in the Post-Mortem Room. In connection with each organ very clear instruction is given as to the mode of examination, a full description of all points to be looked for follows, and finally every morbid condition to which the part is liable is clearly but simply treated of. Much valuable information is to found in all parts of the Book, which is exactly the thing for men who intend taking the appointment of Post Mortem Clerk, in fact for all who are pursuing any pathological work. We very strongly advise all to obtain this excellent little Manual.

A Manual of Necroscopy by A. H. Newth, M.D., London. Smith, Elder and Co., 1878.

Just published, crown 8vo. 5s.

A MANUAL of NECROSCOPY; or a Guide to the Performance of Post-Mortem Examinations. Notes on the Morbid Appearances and Suggestions for Medico-Legal Examinations. For the use of Students and Practitioners. By A. H. NEWTH, M.D.

London: SMILH, ELDER & Co., 15, Waterloo Place.

NOTES OF THE MONTH.

WE have much pleasure in announcing that Mr. John Mackern, late House Surgeon at this Hospital, has been awarded an Open Scholarship for Natural Science, of the value of £40, at Caius College, Cambridge, where he commences residence this May term. The examination was competive, and he took up Physiology and Botany.

Mr. C. G. LEE, M.R.C.S., (Eng.); L.R.C.P., (Lond.), has been appointed one of the Assistant Surgeons to the Liverpool Eye and Ear Infirmary.

BOOKS, ETC., RECEIVED.

NEWTH'S Manual of Necroscopy, Medical Press and Circular, Sanitary Record, Students' Journal, Proceedings of Medical Society of County of Kings.

COMMUNICATIONS received from, Mr. Parhunn, Mr. Rendle, Mr. Lubbock, Mr. G. Mackern, Mr. G. A. Wright, Dr. Bull, Mr. Rudd, Mr. Horrocks.

Aneurism of the Abdominal Aorta.—Nothing is more common in thin hysterical females than to have your attention called to a pulsation in the abdomen. This is merely that of the abdominal aorta of which the coats have probably become dilated through relaxation of the sympathetic. Abdominal aneurism in women is most rare.

Gout.—Exists in two types:—

1.—Diffused in many joints: often inherited; found in weakly anæmic individuals. It requires good living.

2.—Localized to particular joints, and brought on by good living.

Mashed mutton eaten raw is often a splendid food for children. We have seen children walking down straight to the grave, eat raw mutton, turn round, and walk straight back again, getting quite well.

If at the bottom of a constitutional sore you find yellow lymph, *looking like wet wash leather, you may be nearly sure* the sore is due to Syphilis.

Whenever there is œdema of one arm without the other being affected; look for a growth in the neck.

Ozæna is most commonly specific, but may be due to bone diseased from any cause, or to a condition of the mucous membrane analogous to granular lids. In some obstinate cases, the frontal sinuses have been cut down upon with benefit.

Addison's Disease, characterised by the typical discolouration, weak cardiac action, tendency to syncope, dyspnœa anaemia, anorexia, painless vomiting, extreme muscular weakness. Black spots may often be observed on bucal mucous membrane.

In adults the usual sequel of chronic bronchitis is emphysema, in children, bronchiectasis.

Downcast eye is characteristic of hydrocephalus, owing to pressure of fluid upon orbital plates.

ANTISEPTIC GAUZE, BORIC LINT, PURE CHLOROFORM,
and other preparations recommended by Professor LISTER, ANHYDROUS ETHER
for producing Anæsthesia, as used by Dr. THOMAS KEITH.

PREPARED BY

J. F. MACFARLAN & Co.,

Manufacturing Chemists, Edinburgh, & 5, Barge Yard, Bucklersbury, London.

GUY'S HOSPITAL GAZETTE,
JUNE, 1878.

HEMIANALGESIA IN HYSTERIA.
METALLO-THERAPY.

By P. HORROCKS, M.B.

(*Continued from page* 39.)

In the present number will be completed the case of E. B. æt. 26, who was under the care of Dr. Wilks.

February 28th. Complains of pain over sacrum extending half-way up the spine.

March 1st. Tongue very tremulous.

2nd. No anæsthesia, nor analgesia on chest, abdomen, neck, and face.

3rd. Whole of trunk and head and neck normal as to sensation to touch or to pain. Left upper and lower extremities anæsthetic and analgesic.

6th. Face flushed and she complains of great pain in the head. Continues taking Chloride of Gold and Sodium in one-eighth grain doses, in Infus. Calumb. three times a day.

10th. In the evening whilst going round the wards late she was asleep, and on pricking her left hand with a needle she rubbed it first, then took it away, and finally, the pricking being continued, she awoke and then could not feel at all, however much she was pricked.

11th. Being again asleep in the evening her face was pricked on left side and she awoke suddenly.

16th. Two sovereigns applied to left arm, and left on all day.

19th. Four sovereigns applied to left arm for several hours.

23rd. Complains of pain in her leg from her knee downwards.

29th. Can feel now both an ordinary touch and the prick of a needle down to elbow of left arm. The anæsthesia and analgesia are disappearing from above downwards *pari passu*.

April 2nd. Gets up and can walk a little with the aid of a chair. There is no paralysis of left leg, which she holds forwards in truly hysterical style instead of dragging it behind her as hemiplegics do. Complains a great deal of palpitation; heart not acting violently.

8th. Two sovereigns applied below elbow of left arm and left on about six hours.

15th. Can stand better. No difference in arm. Can feel touches and pricks down to left knee.

16th. Two sovereigns applied to left forearm and kept on several hours.

She asks that the sovereigns may be applied because she believes they do her good. She tries to walk every day, but says it makes her heart palpitate so much that she is afraid to use too much effort.

The Glee Club being about to give a Concert to the patients in the Hospital, next Friday week, and all those in Mary Ward who can go being in a high state of excitement, all wanting to be present, this patient is extremely anxious to go and has been told that if she can walk by that time she shall go.

April 25th. She has been trying very hard to walk during the last few days, and, has at last succeeded, in getting down and up stairs herself.

26th. Can walk very well without support. Is going to the Concert this evening.

27th. Went to the Concert and enjoyed it very much; is in better spirits this morning.

28th. Coins placed on arm again. Can feel now half-way down left forearm. Anxious to go home as soon as possible.

May 1st. Patient went home this afternoon. She has had gold coins on arm every day for last few days.

Her condition is as follows:—Anæsthesia and analgesia and loss of sensation to heat and cold from middle of left forearm and middle of left leg down to tips of fingers and toes respectively.

Considerable amyosthenia on left side. No difference in measurement between two sides. No wasting of limbs. No achromatopsia. Special senses quite normal. No anæsthesia nor analgesia in trunk and neck.

Considerable ovarian hyperæsthesia both sides, but especially left side.

She has been taking the Chloride of Gold and Sodium three times a day in one-eighth grain doses now for nearly eight weeks, and this fact has been unknown to her because she took it into her head that she would not take gold, having heard it mentioned at the bed-side, and said she would leave the Hospital first. So a tonic was ordered and the gold put in without her knowledge. The double Salt of Gold and Sodium is very soluble in water, but is apt to deposit a golden film on the sides of the bottle after standing some days.

May 27th. Patient came to the Hospital this afternoon and can walk perfectly well, and is all right except the left hand, which is anæsthetic and analgesic from an inch above lower end of ulna downwards. Left foot is quite normal. She suffers much right facial neuralgia and says her feet and legs often swell very much, at present there is not the least œdema about them. Her grasp is feebler in right hand than in left. She took some medicine out with her when she left the Hospital which lasted a fortnight; it contained Chloride of Gold.

I gave her a tonic and some Quinine to-day but not any more Gold.

Remarks:—I have no wish to deceive myself or others with regard to this apparently mystic method of treatment, and have therefore, laid the facts of the case before any who may be willing to examine them.

No one can deny that there could be no fallacy in this case as to the presence of the hemianalgesia,

and I do not hesitate to affirm the greatest faith in the existence of total hemianalgesia and hemianæsthesia as a condition in hysteria. It is, however, much more difficult to prove the latter than the former; for if one merely touches a patient and asks if she can feel, it is obvious that one has to rely solely on her veracity. The same remarks apply in part to the other phenomena, achromatopsia and impairment of the senses and amyosthenia, &c. Then again in carrying out the experiments one was obliged to let the patient know we were pricking her and so the same source of fallacy crept in. At first she resented being thus treated, but when we pointed out to her that it didn't make her arm bleed and would do her no harm, she made no further objections, and was quite willing to be pricked, as often and as deeply, as we wished. And here one may observe, that some pricks did bleed, and it often happened that a slight prick caused bleeding, when a deep one did not.

With regard to her evidently feeling pricks when asleep on the analgesic side, it is quite conceivable that during that state, reflex action comes more into play, the controlling influence of the cerebrum being temporarily suspended. That she got very much better and indeed nearly well before leaving the Hospital is also a fact; but what caused the improvement is another matter. Was it the internal administration of Gold? It might possibly be so, but it is difficult to see how it acts and quite impossible to say now whether she would or would not have recovered without being given the metal.

Was it the repeated application of the coins externally? That I cannot answer, but the patient herself thought that they did her good and that was the reason why they were repeatedly applied and left on for hours.

One knows so little about the actual condition in hysteria that it is quite premature to attempt any solution of the mystery of its cure. That it is not mere shamming no one with much experience will deny, though the two are often confounded, and indeed with real hysteria malingering is often mixed. To some the application of metals and their internal administration may seem absurd; but surely the application of electricity, shocks from fright, cold baths, &c., which often cure hysterical affections, are no less wonderful in their *modus operandi!* Another point of importance in which I have great faith is the aid or confirmation which it gives in the diagnosis of the hysterical nature of a complaint. If a patient has impairment of her sensations with no organic lesions to account for it we diagnose hysteria. If she has some complaint which is supposed to be hysterical and yet has no impairment of sensation I should unhesitatingly pronounce it to be hysteria if I could evoke anæsthesia or analgesia with metals; though I should not be equally certain of its absence, on failing to get any effects.

One might give many examples. Take one—amaurosis—How many come to eye outpatients with this symptom and no lesion nor defect to account for it! If there be any anæsthesia or analgesia or if these can be produced by metals, the nature of the complaint is rendered positive.

ULCERATIVE ENDOCARDITIS.

An interesting case of supposed Ulcerative Endocarditis is at present in Clinical Ward, and Dr. Goodhart has kindly permitted the following account, taken from the report of Messrs. E. C. Beale and D. D. Malpas, to be published in the *Gazette*.

S. C., æt. 22, fancy box maker; admitted 23rd March, 1878.

Personal history.—With the exception of having had children's diseases, from which patient made a good recovery, she has enjoyed good health until about seven weeks before admission, when she cut her finger badly, and subsequently poisoned the wound whilst washing. Some suppuration ensued up the sheath of the extensor tendor of the left middle finger, and the finger was eventually amputated at the metacarpo-phalangeal joint. The wound healed without further inflammation, but patient states that since the accident she nas never felt in health. During the last few days she has had occasional pain in the præcordial region. Ten days ago she suddenly lost the sight of the right eye, a blue film appearing to come before it, excluding all light. The left eyeball ached severely when she tried to read, but the sight was scarcely affected at all. Three days ago had severe pain across the epigastrium and on the left side over the spleen; the bowels were open, but there was a slight attack of vomiting. The pain continued for two days, and she could not bear the weight of the bedclothes. Yesterday the pain became less.

Family history.—Parents died of rapid Phthisis; two brothers living, and healthy.

On admission.—Patient is a pale, sallow, delicate-looking woman. Pupils dilated, right hardly reacts at all to light; she is completely blind on this side.

The ophthalmoscopic examination indicated plugging of the Arteria Centralis Retinæ.

Lungs.—Healthy.

Heart.—A rather hard blowing systolic murmur is audible at the apex; apex beats below and a little internal to nipple; heart sounds at base normal; percussion normal.

Abdomen.—Tender to pressure on left side, where a lump can be felt projecting below the ribs, giving dulness, which is continuous with that of the spleen.

Liver.—Dulness extends a little below the margins of the ribs on the right side. Urine, sp. gr. 1,015; no albumen or sugar.

March 23rd.—Sleeps badly, pain less acute, no action of bowels, sweats at night; temp. 98°.

March 28th.—Feels much better; has sweated profusely the last two nights.

April 6th.—Patient feels well; no return of sight; spleen about the same.

April 27th.—Not so well to-day, having caught a chill when going to the concert last night.

May 4th.—Yesterday afternoon became very unwell, complaining of pain in the stomach and on the left side. In the evening she vomited twice. In the night was seized with severe pain in the splenic region. Pil. Opii. gr. I., VI. tis. horis. The blood was examined, and found to contain an excess of granular matter. No excess of leucocytes.

May 5th.—Pain still complained of in splenic region; temp. 98.2°, P. 110.

May 6th.—Pain less severe.

May 9th.—Is much better and wishes to get up. Pil. Opi. discontinued.

May 25th.—No return of pain, and feeling comfortable.

June 4th.—Patient still feels well and gets up; the condition of the spleen and murmur heard over the heart's apex being unaltered.

EPITHELIOMA OF ŒSOPHAGUS. GASTROSTOMY.

The following is a short summary of an extremely interesting case admitted into Naaman Ward under Mr. Howse. Dressers, Messrs. Stanley Taylor and George Pilkington.

W. M., æt. 46, admitted April 21, 1878.

Family history.—Good.

Previous history.—Had an attack of pneumonia in March, 1876, and was under treatment at his home for ten weeks. He has lived pretty freely.

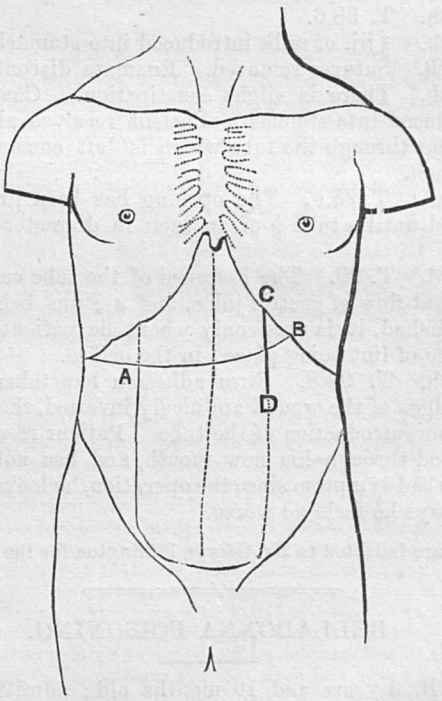
Present illness.—A year ago the first noticed a difficulty in swallowing, which has rapidly increased, until on admission he can scarcely take even liquids with comfort. He has lost flesh rapidly during the last year. There is no dyspnœa.

On admission.—Patient is a very spare man, nails much clubbed. No affection of voice. Chest: slight dulness under right clavicle and over upper $\frac{2}{3}$ of right lung behind. Rough prolonged expiratory murmur. Liver dulness greatly increased downwards and to left. On auscultation of œsophagus a splash is heard as he swallows over the last cervical vertebræ, nothing heard lower down, arteries rigid, pulses equal, great vessels at root of neck normal. He can hardly swallow even fluids. There is great pain between shoulders, and on pressure of fourth dorsal vertebra.

He was ordered eggs, beef tea, milk, which he was able to swallow although with difficulty, until four days after admission, when the obstruction became more serious.

On April 26th, he was seen by Dr. Goodhart who agreed with Mr. Howse, that the absence of dyspnœa, the voice being natural and the rapid increase of dysphagia, pointed to a malignant growth.

April 28th. Mr. Howse passed a small œsophogeal tube, this met with some obstruction opposite fourth dorsal vertebra, but on slight manipulation it passed into the stomach. On withdrawal, a small piece of some growth was found in the tube. This hardened and examined by Mr. Crooke, one of Mr. Howse's dressers, was found to be a fine specimen of epithelioma. Difficulty of swallowing increasing, and as the patient was gradually getting weaker, Mr. Howse (May 6th) performed gastrostomy.



(The margin of the liver was previously marked out in ink, and the diagram will show the extent to which hepatic dulness reached (A B), and also the line of incision (C D).

Chloroform being administered, Mr. Howse made a vertical incision two-and-half inches long through the abdominal walls into left hypochondriac region, each layer being carefully divided. A few small vessels were tied, the peritoneum was divided and the left edge of the liver was seen. After a short time the stomach was seized with a pair of forceps, and secured to the edges of the wound by sutures of strong catgut, but not opened, Mr. Howse, thinking it would be safer if adhesion between the stomach and

parietes was allowed to take place before he did so. The operation was performed under the spray and the wound was dressed with gauze. Slight sickness after operation.

May 7th. Had a good night. T. 98.4. Ordered an enema of pounded meat, egg and milk with twenty grains of pepsin and ℥ xx. of dilute Hydrochloric Acid.

8th. T. 98. Feels weak.

9th. T. 98. Slept well. No pain about wound.

10th. T. 98.4. Complains of thirst and feeling of hunger. Adhesion has taken place between stomach and parietes.

11. T. 98.4. Patient taken into theatre, and an incision made into stomach. Chloroform was not given, and he scarcely felt the knife; a No. 11 Cathether was passed through the opening.

12th. T. 98.6.

13th. ℥jjj. of milk introduced into stomach.

18th. Sutures removed. Enemata discontinued.

20th. There is slight constipation. Castor Oil introduced into stomach. Patient receives all nourishment through the tube which is left constantly in stomach.

22nd. T. 98.6. The opening has been gradually dilated until a tube $\frac{5}{8}$ of an inch in diameter is now used.

23rd. T. 99. The presence of the tube causing a constant flow of gastric juice, and a sinus being well established, it is used only whent he patient is fed, a piece of lint being placed in the orifice.

26th. T. 98.8. Firm adhesion has taken place, the edges of the wound are nicely inverted, there is no pain on introduction of the tube. Patient receives all his food through his new mouth, and has not had a single bad symptom since the operation, he looks better, and says he feels no worse.

[We are indebted to Mr. George Pilkington for the above]

BELLADONNA POISONING.

C. B., 3 years and 10 months old; admitted into Clinical, May 16th. His mother said that about 2 p.m. he swallowed some liniment, given to rub on his little brother's chest, who had whooping-cough. The bottle was brought to the hospital and was found to contain Belladonna. There was a very small quantity in the bottle, and of this he only swallowed two or three drops. Shortly afterwards he went to sleep, and remained quiet for an hour or more. He then woke up screaming; he clenched his hands and tossed about, and was frequently seized with tremblings and convulsions.

He was admitted at 6 p.m., when his pupils were much dilated and conjunctivæ injected; his face seemed swollen, especially about the eyelids. His tongue was moist, the pharyngeal mucous membrane felt much swollen to the finger. He seemed quite delirious, and did not recognise his mother; he was drowsy, often screamed and put his clenched hands up to his mouth, and had frequent slight convulsive attacks. Breathing was much accelerated, inspiration being accompanied with hoarse sucking sound and elevation of alæ nasi.

He was given Zinci Sulph. gr. x, but swallowed not more than half of the solution; was then given milk and brandy in spoonfuls; he had great difficulty in swallowing this, his efforts causing spasmodic cough and congestion of the face. A quarter of an hour after the first was given a second dose of Zinci Sulph. gr. v. This was shortly followed by vomiting; matter had no characteristic smell. After this his breathing was easier. He was then ordered—

Acid Tannici, gr. v.
Syr. Mori, ʒ half-hourly.

At 10 p.m. he was still delirious, but altogether quieter and easier.

The next morning he was quite conscious, and seemed very comfortable; his tongue was clean and moist; pulse, 96; pupils, still dilated.

19th.—Pupils, normal; pulse, 96; seems quite well, and left the hospital.

[We have to thank Mr. E. B. Grainger for the above.]

ADULT SPINAL PARALYSIS.

It was erroneously stated in the *Gazette* of May that post-mortem evidence had supplied no information as to the lesion in adult spinal paralysis, since, Dr. Hammond, in his work on diseases of the nervous system, does record a case in which the post-mortem inspection was made, owing to the patient having died of another disease. In this case the patient was suddenly paralysed in the four extremities, the paralysis beginning in the legs and rapidly extending to the arms, while sensation was unimpaired. There was muscular wasting; loss of electric contractility, and the other symptoms of the disease being also present. After two years of complete immobility the patient began to amend, but before the amendment was complete he died from another disease.

Dr. Hammond records the post-mortem examination as follows:—

"On post-mortem examination the membranes of the brain and cord were found to be healthy, and to the naked eye there was no lesion of either of these organs.

"The histological examination of the spinal cord was made after hardening in solution of chromic acid and colouring with carmine.

"The white substance throughout all its extent exhibited no traces of disease. Only the columns of horizontal fibres which emerge from the anterior horns to form the fibres of

origin of the anterior roots showed a notable diminution in size. The posterior commissure and posterior horns were normal. The lesion was almost entirely confined to the area of the anterior horns, and here it only concerned the large nerve-cells called motor cells. The walls of the vessels had suffered no change; they were of normal thickness, and the sheath was free from granular bodies. Moreover, there was not in the neuroglia any trace of the existence of an irritative process, such as the proliferation of the neuroglia.

"As to the alteration of the nerve-cells, it was such as is met with in progressive atrophy of these elements—yellow pigmentation. The lesion was diffused; it had struck here and there the nervous elements, of which a certain number had disappeared, for in some sections only fifteen or twenty could be counted.

"The cells which did not exhibit this yellow pigmentation were nevertheless reduced in size.

"This was the first full investigation made relative to the morbid anatomy of spinal paralysis of adults."

Dr. Hammond believes that the data are therefore quite sufficient to enable spinal paralysis of adults to be placed in a definite patho-anatomical position, as depending upon inflammation of the anterior tract of gray matter, and the consequent atrophy and disappearance of the cells constituting its nervous elements.

It should, perhaps, be mentioned that Dr. Hammond is "Professor of Diseases of the Mind and Nervous System" in the medical department of the University of New York.

MONTAGU LUBBOCK.

GUY'S HOSPITAL ATHLETIC CLUB.

A General Meeting of the above was convened on Monday (3rd of June), to elect officers for the present season and to settle definitely whether Guy's sports should be held or not.

Mr. Elliot being voted to the chair, after making a statement as to the financial position of the Club, passed on to the election of a Secretary, which post is vacant owing to the resignation of Mr. Walter Gray. Mr. Edwin Roper, proposed by Mr. T. H. Fraser, seconded by Mr. L. Stokes, was unanimously elected, and informed the members present at the meeting that Mr. Durham and Dr. Moxon had kindly consented to act as vice-presidents, representing Guy's at the United Hospital Sports, which are to be held at Lillie Bridge, on Saturday, 29th June.

The next officers to be elected were the members of the Committee; the following were elected:—Messrs. T. H. Fraser, A. H. Jackson, W. G. Growse, L. Stokes, A. Scott, F. T. Wilkinson.

Gentlemen to collect subscriptions for the sports were then nominated of whom the following were elected:—First year, W. G. Growse, B. Scott; Second year, H. G. Ashwell, F. H. Shaw; Third year, A. Scott, R. E. Morse; Fourth year, E. Penny, F. T. Wilkinson.

In case that gentlemen are ignorant of the duties of the above it should be mentioned that £30 has to be collected for the United Hospital Athletic Club and also money to defray the expenses of our own sports.

It is to be hoped that gentlemen will come forward rapidly and enter their names for our own sports, as the larger the field the better chance we have of being able to send up good men to represent us at the United Hospital Sports; and the Foot Ball Club having failed to retain the Cup, it rests with the Athletic Club to keep up the reputation of Guy's as being one of the foremost Hospitals at Athletics.

Mr. E. Roper has since been obliged to resign his appointment as secretary owing to his being unable to give up his time necessary.

A committee will be therefore held shortly to elect some one in his place.

THE UTILISATION OF SEWAGE.—A meeting was held on June 3rd at Stafford House, for the purpose of discussing the national importance of General Scott's Cement Process in preventing the pollution of rivers, as adopted at Burnley, Lancashire. The Chairman said that a meeting was held at Stafford House in 1872, and Scott's Sewage Company was formed a year afterwards. Ever since then the directors had been trying to show to the world that General Scott's process was a right one. It had been tried at Burnley, and the time had come when it would be shown how the process worked there. When he himself went into the company, it was not with the notion of making five or ten per cent., but with the idea that it was a national work. Sir Henry Cole showed specimens of the filthy sludge of Burnley, which, he said, was of about the same description as that of other towns, which, by having lime put into it in proper quantities, became clarified. With a sufficient quantity of lime the water was quite clear. The deposit contained what was necessary for making cement. If cement were to be made either in St. James's Park or at Burnley there must be a certain proportion of lime, silica, and of alumina. In General Scott's process were the ingredients for cement, and according to the quantity of lime used was the Portland, Roman, or agricultural cement produced. Birmingham had great difficulties as to what to do with the sewage; but all sewage had so much organic matter in it that it would burn of itself, and produce a clinker that any cement manufacturer's eye would be charmed with it as a proper material to convert into Portland cement. That was going on every day at Burnley. It still remained to perfect an exact system of filtration. At Bradford, after trying various systems, they had now a system of filtering a lime effluent through coke, and as far as it had gone it was a great success; but they had not yet hit upon what to do with the solid matter. General Scott's system at Burnley instead of sending the stuff into the river, purified it, and made cement of thes ludge. Towns must learn to pay to be clean; this company could produce a clear effluent; and if a town would pay for it the question was solved. The system he was speaking of was more particularly applicable to London, for if there was one place in the country that had a monopoly for filth it was the Thames. To make London clean in its water would cost only sixpence per head.

THE Rev. James Philip Flood has been appointed chaplain to the hospital in the place of the Rev. H. P. Vernon, who did not accept the appointment.

MR. ALFRED W. STOKES of Guy's Hospital has been appointed Analyst for the parish of Paddington.

GUY'S HOSPITAL GAZETTE,
JUNE, 1878.

A GLANCE at the Notice Board in the Colonnade would satisfy anybody that the Summer Session at Guy's is by no means the idlest season of the year. Never, we suppose, has such an array of Classes, Demonstrations, and Lectures appeared there before. Instruction is obtainable in the behaviour of Chemical Salts and Solutions, and also in the habits of Lunatics; one man is invited to observe for himself the beautiful spiral vessels of plants, while another is as cordially invited to study the pretty nests containing deadly cancer cells, and so on, from Matriculation to the 2nd M.B.—the Student, weary with the weight of many volumes, can avail himself of the experience and help of those who have safely passed the shifting sands and shoals of examination. Men doubtless eagerly receive such help, and are grateful; for, be it remembered, the holding of most of the classes is a purely voluntary act on the part of those whose time is precious. A stranger might perhaps take all this as evidence of "cram," and more especially as he would see the names of the various Examinations over many of the notices of classes; but a short trial would soon dispel any such idea. The method generally adopted is to state the *facts* of the subjects, so far as they are known, as clearly as possible to the members of the class; then comes the arranging and condensation of these facts in such a way as the experience of the teacher may deem best. This latter process certainly has an "Examination" end in view, but the principle on which all teaching ought to hinge is that knowledge is power, whether for examinations or for practical purposes. The man who has the most knowledge intelligently arranged in his mind is the man who will do best in examinations and in practice. It was well said by *Pilocereus Senilis*, that "at Guy's we try to teach and encourage you to learn things rather than words," and a good example of this method may be seen in the admirable Demonstrations on Skin Diseases which are given every Tuesday. A patient comes into the room with a skin eruption; a student is then selected, and first requested to state what he sees, the physical characters and distribution of the eruption or eruptions; he is then asked to state what parts of the skin are involved in the morbid process, then the nature of the morbid process; whether due to inflammation, Atrophy, &c; then he is expected to name the disease; further, the prognosis is required, this also leading to a discussion on the causation; finally, the treatment and its *rationale* are gone into. This is, in brief, the system adopted, and the amount of knowledge thus gained in going over one case is much greater than that obtained in cursorily going over a large amount of cases in the same amount of time. The principles of such a system are also applicable to the scientific and preliminary medical studies, though obviously not so to the abstract sciences; happily, however, the amount of these latter, necessary for us, is limited. A man, then, who has accustomed himself in his first two or three years to examining things in this way will find it all the easier afterwards to track his way in the misty chaos of modern pathology.

INTESTINAL OBSTRUCTION.

By G H. RUSSELL.

THE PRIZE PAPER OF THE PHYSICAL SOCIETY.

(*Continued from page* 58.)

INTERNAL STRANGULATION.

Internal Hernia. [CASES 36 to 45].

Etiology and Pathology—

In these cases a loop of bowel is strangulated through some natural hole in the peritoneal cavity, or by a band, &c. At any rate it *is* strangled, and the clinical course is therefore very similar to that of strangulated hernia.

The constricting agents have been in my own 9 cases as follows:—

(1)—In four cases bands of inflammatory lymph attached as follows:—

Binding down the intestine to the psoas.
To the pelvis.
To the mesentery.
To the colon.

(2)—For one case a band composed of a diverticulum of the ileum with a cord of lymph at the end.

(3)—By appendix cæci whose end was attached to promontory of sacrum.

(4)—Through a hole (acquired) in the lower part of the omentum.

(5)—Strangulation in R. Femoral ring.

In Dr. Fagge's 17 cases the agents were—

In 8, bands of lymph.
In 5, diverticula of the ileum with lymph cords at their end.
In 1, a band connected with vermiform appendix.
In 1, the pedicle of an ovarian tumour.
In 1, the mesentery of a coil of ileum.
In 1, the neck of an internal hernial pouch.

NOTE—That in 8 out of these 26 cases, *i.e.* in $\frac{1}{3}$ of them, the band was of such a character that

(*a*)—It would probably not have its character recognized during an operation, and

(*b*)—It could not be divided without danger of fæcal extravasation.

Clinical History:—Is well marked. The only thing one would be likely to mistake it for is strangulated external hernia.

Average age of patients 40 (from 20 cases); onset sudden and definite; duration only a few days; collapse early and severe; vomiting and pain early and constant; constipation complete; urine small in quantity, or suppressed; abdomen not greatly distended; death from collapse. Here is a case (case 36).

J. H. 46. Hernia of 2 years standing—

Jan. 23.—Carrying load—sudden pain—same day vomited.

„ 25.—Complete constipation. Still vomiting. He came in for strangulated hernia, and the ordinary operation was performed without any benefit. He died on February 6th.

P.M.—Last 2 feet of ileum bound down to psoas by a band of inflammatory lymph.

Note here the resemblance of the history to that of external strangulated hernia. Hence the operation.

Also the old hernia. About ⅓ of the cases (3 in 9) of internal-strangulation have old herniæ. In others there is a history of old peritonitis.

Termination—Recovery is very rare, and the prognosis, when the symptoms are marked is bad. Yet recoveries do take place. Thus case 41 had had a former attack lasting five days. [He died after gastrotomy, and an empty peritoneal band was found in the abdomen.]

INTUSSUSCEPTION.

Cases 46 to 51. See also case 30.

Fatal Cases:—

1854 to 1869—8 cases.				1869 to 1876—7 cases.		
	SEX.	AGE.			MONTHS.	
Rectum	Female.	35.		Rectum Female, 44.		No lump.
Ileo-Cæcal	Male.	14.	} 3	Ileo Colic, Male at	7	} lump.
	Male.	5.		Female at	6	} No. 3.
	(?)	44.		Male at	6	} lump.
Ileal	Male.	16.		Ileal Male at	20.	No lump
	Male.	25.		Female at	22.	(?)
	Male	17.		Female	(?)	
	Female	16.				

There are three layers within one another called respectively the entering, returning and receiving layer; the entering layer being innermost, the receiving layer outermost, and the returning layer connecting the lower end of the entering with the upper end of the receving layer. The venous blood being prevented from returning from the two inner layers, these become congested, discoloured and finally gangrenous.

There are two natural terminations of such an intussusception.

1.—The two inner layers being gangrenous may slough, and be discharged per anum.

2.—Or the ulceration which takes place at the beginning of the entering part may cause perforation and death (case 49).

There may be intussusception of any part of the intestine—Jejunal, Ileal, Ileo-Colic, Rectal.

Of Jejunal we know nothing except that it is said to resemble ileal.

Of Rectal we know two cases, the persons aged 35 and 44. In one case the intussusception came down through the anus. In the other there was cancer as well, and the whole could be felt per anum as a pear-shaped mass.

In both the progress of the case was very chronic (more than a year in one). The one patient died of obstruction, the other after colotomy.

Ileal and Ileo-colic are the two chief kinds. They have the following symptoms in common. The onset is definite and sudden—the symptoms being pain, sickness, constipation, not usually complete, the discharge of blood per anum, and sometimes a tumour.

Ileo-colic Intussusception occurs almost invariably in children, in fact the first thing that usually strikes you in reading a case is that the age is put in months. We have 5 certain cases on record, the ages being 6 months, 6 months, 7 months 5 years, 14 years. Twice I have known two children in the same family to have intussusception.

This is the sort of history—repeated again and again—

June 11th. Harry Innman, æt. 7 months, bowels open, soon after was sick and blood was noticed on his napkin, 5.15 of same day he came in. Sudden screams as if in pain. Sick again, bowels open, with blood in motion, tumour felt to the left of the median line in left Hypogastrum after inflation it disappeared.

June 12th.— Tumour as large as ever.

„ 13th.—Operation proposed, chloroform given, no tumour.

„ 14th.—Seemed better.

„ 15th.—Bowels opened. Death.

In the above case notice—

1.—The duration. The ileo-colic is more chronic usually than the ileal, yet it very seldom deserves the term chronic, the duration of 5 cases being 5 days, 3 days, 12 days, 24 days, and 4-5 months. Thus only one was chronic and this died 4 days after *strangulation* and the passage of blood per anum.

2.—Blood per anum. This comes on only when the intussusception is strangulated, and is an urgent call for instant treatment.

3.—The constipation—never complete and certainly not the cause of death.

4.—The tumour. This is always present of course, but in only about ⅔ of the cases can it be felt, sometimes per rectum, sometimes only by adominal palpation. It is always in some part of the course of the colon, generally to the left of the median line. It is elongated, it moves its position, above all it hardens and enlarges and then subsides under peristaltic action.

Ileal intussusception—

The clinical history closely resembles that of Ileo-Colic, Intussusception, but

1.—Ileal occurs in older people—ages in years 20 (6 months ?) 22, 16, 25, 16, and 17. Twenty-five years is the greatest age I have seen in a case of intussusception.

2.—Ileal is usually shorter in duration than Ileo-Colic, and sometimes kills in an awfully short time. Duration:—15 days (colotomy), 2 days (gastrotomy), 8 days, 2 days, 2 weeks.

3.—The symptoms are usually urgent—constant fæcal vomiting, much peritonitis, abdominal distension, &c.

4.—You can very seldom feel a tumour.

5.—Sometimes in Ileo-colic intussusception you get premonitory symptoms, especially violent attacks of pains, for perhaps months. This you never get in ileal, which goes on steadily and progressively.

Termination of intussusception—

The mortality is very great, sometimes from perforation, sometimes from collapse, sometimes from over zealous treatment, sometimes from stricture. I have 8 cases of fatal intussusception. I have only been able to find 3 cases of non-fatal intussusception.

The case may end favourably either by the separation of the included part or by its reduction by treatment.

GENERAL DIAGNOSIS.

If a patient comes to you with constipation, and pain and swelling in the abdomen, don't give him purgatives, but put him on Opium, with a light diet, and think over his diagnosis.

The things you would be likely to mistake for intestinal obstruction, are cæcitis, pericæcitis and ulceration of the cæcal appendix; or peritonitis.

Put the man on Opium, and in a day or two the addition to the constipation, pain and swellings, of vomiting, or visible peristalsis, &c., may settle the doubt.

Suppose, however, the symptoms are those of obstruction.

Then are they chronic, or are they urgent?

If chronic, stricture of the large or compression of the small intestine are what you should think of.

Is it stricture of the large intestine?

Can you feel it per rectum? If not, it is not syphilitic?

Is there a history like that of cancerous stricture? Is there a tumour to the left of the median line? Is the colon visibly distended, with visible peristalsis and gurgling? Is the vomiting slight and late? Is there plenty of urine? Is the abdominal distension chiefly in the flanks? Then cancerous stricture.

Is it compression of the small intestine?

The symptoms here are chiefly negative. Nothing felt per rectum, no discharge per rectum, abdominal distension, but not chiefly in course of the colon, distended coil of intestine with visible and painful peristalsis, vomiting, but no collapse, suppression of urine, &c.

If then you get a chronic case, as shewn by visible peristalsis and by the history, you have to determine whether it belongs to the large intestine (stricture), or to the small (compression).

The Case is Acute. } Internal Strangulation. } Intussusception.

Are the symptoms those of stranugulated hernia—*i.e*, constant severe retching and sickness, complete constipation, a cold clammy skin, frequent feeble pulse, then look for a hernia—if you don't find one it is *Internal Strangulation.* If you do find one and operate, and yet the symptoms continue, then again it is *Internal Strangulation.* Additional tests: No tumour, nothing passed per anum, oldish subject.

But is the patient young, a child, did it have pain, then sickness, then blood per anum? Intussusception. If you can feel a tumour in addition to these symptoms, you are quite sure.

If not you have to distinguish between Ileal Intussusception and Internal Strangulation, which is easily done as a rule not only by the above characters, but also by the fact that in Ileal Intussusception you get some slight fæces passed as a rule.

You will be liable to mistake fæcal tumour for intussusception, and vice versa, which has often been done when the chief symptom is a tumour. But a few injections usually settle the point.

If the symptoms do not allow of your placing it in either of the four cases, endeavour at least to decide if it be in the small or large intestine, by carefully noting the shape of the abdomen (pain, vomiting, urine, distension).

TREATMENT.

The treatment is to some extent the same in all cases, thus you put the patient on Opium, or Opium and Belladonna; give him only liquid food and keep him in bed.

If the obstruction is the chief thing, you may further give enemata. If the abdomen be greatly distended, and gives the patient great pain, the intestine being distended with gas, &c., the question of tapping with a fine trochar and cannula arises, and such operation may be done, but only if the inconvenience is great. Remember that though such an operation has once proved fatal (case 6), the distension which it remedies has often proved fatal (case 21 and 24).

If it be a Stricture—

If it be syphilitic you may give Mercury and Iodides, and pass a bougie up the rectum.

The usual treatment of such strictures used to be to pass a bougie till the patient would not have bougies passed any longer, and then send her out. They did not do much good. But do not pass a catheter with a Stilette, or you will probably, and do not forcibly dilate the stricture, or you will almost certainly kill your patient.

If the patient does not improve, there remains only the operation of Colotomy in the left loin. It has been done twice, once successfully, the patient being alive and well a year after, once unsuccessfully, the patient who was well nourished, and in good health, dying a fortnight after the operation, of suppurative peritonitis.

The reason why Colotomy has not been done oftener in such cases I take to be, that the obstruction induced by the stricture seldom threatens life, and to kill a young (æt. 29) healthy woman, because of a stricture, which only *inconveniences her*, is terrible.

In simple Stricture—

Congenital—usually a band of mucous membrane. Mr. Davies Colley in one case divided the band by a ligature, and saved the patient's life. If the stricture cannot be reached, and threatens life, do left colotomy, as you may be quite sure that the stricture is in the rectum.

Due to Ulceration.—You can usually do nothing for such cases but Colotomy, and that has not been very successful. I can only find four cases, and they all died, and all died of the operation.

In Cancerous stricture of the Rectum.—It is for this affection that Colotomy is usually performed, as no other treatment is of the least use, and as the man will certainly die unless treated. During the last 8 years Colotomy (left) has been performed for cancerous stricture of the rectum 13 times. Counting those as fatal cases who died within a month of peritonitis, &c.. we have

Non-Fatal	5
Fatal	8
	13

Of the 5 non-fatal cases 2 went out tolerably well, and were lost sight of; a 3rd died of cancer 11 months after the operation; a 4th, 3½ months after, a 5th, 24 days after (no peritonitis).

Of the 8 fatal cases, two died in spite of the operation, and 6 as a result of it; the former both died of secondary cancer, there being no peritonitis.

The other six died—

Interval Before Death.	Cause of Death.	Condition of Health.
1, after a month...	Sub-peritoneal Abscess...	"Very good."
2, after 26 days ...	Acute peritonitis ...	(?)
3, after 5 days ...	„ „	"Healthy but thin."
4, after 3 days ...	„ „	"Rather wasted."
5, after 3 days ...	„ „ ...	(?)
6, same day ...	Fæcal Extravasation. ...	(?)

It is only just to the operation to say that in two or three cases the fatal result was due to some mishap quite accidental.

With regard to the condition of the patient at the time of the operation, not much can be said, except this, that of two out of the 6 patients who died of the operation it is distinctly stated that they were in good health.

If the cancer be not in the Rectum, but the history, the presence of a tumour, &c., make you quite sure of your diagnosis, do Colotomy in the right loin. I have notes of 4 cases of Colotomy in the right loin as follows—

1.—Cancer. The patient died 3½ months after, of exhaustion.

2.—Intussusception of the Ileum. Death 4 days after from peritonitis.

3.—Doubtful disease; patient alive and well a year after.

4.—For mass of cancer pressing on colon; the man was in a bad condition, and only survived a few days.

Hence two cases were successful, and 2 unsuccessful.

(Success = the relieving of the symptoms for a time).

N.B.—Summary of the results of Colotomy.

CAUSE.

Left—	Fatal.	Not Fatal.	
Simple Stricture of Rectum	4	0	= 4
Syphilitic	1	1	= 2
Cancerous	8	5	= 13
	13	6	= 19
Recto Vaginal Fistula		1	
	13	7	= 20

Right—
Successful 2.—Unsuccessful 2 ... ... = 4

24

Mr. Bryant thinks that were Colotomy performed in tolerably healthy subjects, not 1 in 50 would die.

In cases of Compression, you put the patient on Opium, and give injections (Oi. to Oij. of soap and water) as soon as any peritonitis may be subdued.

Supposing the obstruction to be great (or complete) you may perform Enterotomy. For this you require a distended—permanently distended—coil of small intestine. This you treat exactly as the colon is treated in Colotomy, *i.e.*, you cut down on the small intestine, stitch it to the sides of your incision in the abdominal wall, and then open the intestine, so making a false anus (Nelaton's Operation).

This operation has only been done twice at Guy's, by Mr. Bryant. They were both successful. Each was a typical case of compression. In each the distended coil cut down upon was in the right Iliac Region. In neither case did the temperature rise above 99.2°.

The objections to the operation are, that as the anus is in front, and as fæces, when liquid, are constantly passing, the patient suffers much from the smell of the fæces, and at first from pain when they pass. His chief other troubles are sickness, painful peristalsis, and sleeplessness; but these are temporary. With regard to his permanent trouble—the artificial anus—it is surely better for a man to live with his anus in front, than die with it behind.

The treatment of Internal Strangulation depends on whether there is, or is not a hernia, *i.e.*, on whether there is or is not a guide in an operation.

1.—If there be a hernia, you take it for granted that it is strangulated, or that the strangulation is in its immediate neighbourhood, as bands are often found in connection with old herniæ. If then the hernia be down, you perform the ordinary operation for hernia, and subsequently extending your incision explore the immediate neighbourhood in search of a band. If the hernia has been returned and is found as a soft swelling in the right or left Iliac Fossa, you make an incision over such tumour, open the peritoneum, search for and divide any band there may be, sew up the peritoneum, &c., give the patient a grain of Opium, put him to bed, and keep him on Opium, and liquid food for some days.

This operation has only been performed twice at Guy's, once by Mr. Bryant, once by Mr. Howse, once with all the pomp of spray and gauze, once non-antisceptically. But in both cases the patient was *in extremis*, in both there was a hernia as a guide in the operation, in both the operation extended only to the immediate neighbourhood of such hernia, and both were successful.

In Mr. Howse's case (a man of 33), the temperature never rose to 100, the patient went on without a bad symptom; five days after the operation, his bowels were opened copiously and painlessly; within a fortnight he went out.

This operation then is excellent in its results. It is done for a man *in extremis;* it gives him perfect health, without any such inconvenience as an artificial anus. It has hitherto been successful, and in the future there is no reason why it should be more (or much more) fatal than the operation after strangulated hernia.

This may be called Abdominal Section with a guide, and is in striking contrast as regards its results with the next operation I have to mention.

2.—If there be no hernia, the real difficulty comes. Shall we leave the man alone after giving him Opium, in the hope that the intestine will slip from beneath the band, or out of the hole in the omentum? Or shall we operate without a guide?

Abdominal section without a guide is of this kind—

An incision is made, usually in the middle line, say from an inch above the umbilicus to an inch above the pubes, the peritoneum divided, the hand introduced into the peritoneal cavity, if necessary several feet of the intestine are pulled out and wrapped in towels, if any band be found it is divided; if the intestine burst (as it has) it is sewn up again; if fæces be extravasated the peritoneal cavity is sponged out; if the peritoneum breaks away, after being sewn up, it is sewn up again; and the abdominal incision being sewn up, the patient is put to bed, and left to recover from his collapse, and die quietly.

This operation is not remarkably successful. There have been seven cases, 5 for supposed Intestinal Strangulation, and 2 for Intussusception. The number of deaths has also been seven. Every patient operated on has died within 24 hours (see appendix II. Gastrotomy). Not only so but in most cases had the patient had two or three lives he would have lost them; *e.g.*, the patient dies from shock of operation, but if he had recovered from this there would have been General Peritonitis after fæcal extravasation; moreover in ⅓ of the cases of Intestinal Strangulation the "band" is of such a character, *e.g.*, formed of fæcal appendix (case 38), or diverticulum + band (case 39) that if found it could not be divided without danger of cæcal extravasation.

This operation seems to me more than unsuccessful—unjustifiable—and my advice to any one about to perform it, would be the same as Punch's advice to a man about to marry—"Don't."

To be sure if you leave the patient alone there is but a very slender chance of his recovery. Still there *is* a chance, while if you operate there is none. Thus in one case (41), the man had had a previous attack of Intestinal Strangulation, for 5 days, and at second attack Gastrotomy was performed, and he died. At the P.M. there was an old empty band, and a new divided one. Had this man been let alone, might he not now have been walking about with two empty bands in his abdomen?

Hence if there be no guide (hernia or tumour) don't operate. There is a slender chance of his getting better, but any rate it is better that he should die than that you should kill him.

I beg you to note that in all cases in so far as operation is concerned, the treatment depends on physical signs—something you can see or touch.

(*e.g.*) If you can feel a stricture per rectum—Left Colotomy.
If there is a lump to left of the median line, with greatly distended colon—Right Colotomy.
If a permanently distended coil of small intestine whose peculiar "tumbling" movements you can plainly see—Enterotomy.
If an old hernia with Strangulation symptoms—Abdomnal section, with the hernia as a guide.

The only operation thus excluded is the exploratory operation to find the band (Abdominal section without a guide), and this operation I hold to be unjustifiable.

The most successful treatment of Intussusception—almost the only successful treatment—is by Inflation, and it is this that has cured in three successful cases, the only ones I have been able to find.

Wm. Singer, æt. 5 months—Dr. Wilks, in Clinical, 1870.
Thos. Innman, 9 months—Dr. Fagge, Clinical, 1870.
Emily Freemantle, 6 years—June, 1874.

The nozzle of a proper pair of bellows is introduced into the rectum, and the intestine gradually inflated. The only proof of the Intussusception being gone is the disappearance of the tumour, which may re-appear in a few days, and then with similar treatment again dissappear.

This treatment however, which often cures, sometimes kills. Thus in one case the intestine burst (48); in another its peritoneal coat was cracked below the intestine in all directions. [The patient died of General Peritonitis]. Hence above all thing, no zeal. Be gentle. Remember how brittle the peritoneum is as regards sudden distension.

Again, I doubt if in the ordinary cases of Intussusception, *i.e.*, the comparatively acute Intussusception of children you can do much after the 10th or 11th day. Thus the cases that

recovered did so before the 10th day. In one (case 49) who died on the 11th day, the intussusception was so closely united by inflammatory lymph that it could not be pulled out without rupture, even on the P.M. table. In another there was a band of ulceration at the beginning of the intussusception (case 47) which would probably have given away had any attempt been made at reduction.

Hence if you get a chronic case in which inflation, injection of oil, &c., fails, there only remains the operation of abdominal section, which we have seen to be so unfavourably unsuccessful in Intestinal Strangulation.

This has been twice performed for Intussusception at Guy's. Both times unsuccessfally. But Dr. Hilton Fagge has had a successful case in private practice. Hence if there were clear physical signs of Intussusception, and it had resisted other treatment. I am not sure, but that if the patient were an adult (Dr. H. Fagge's patient was an adult; the operation has always failed in children) opening the abdomen and reducing the intussusception would not be justifiable.

CHLOROTIC CLARA, M.D.;
OR,
THE PATHOLOGICAL PAPA AND THE ANÆMIC ALFRED,
A MEDICAL ROMANCE.

CHAPTER I.
THE PATHOLOGICAL PAPA.

"Omnis meus ego et Eliz. Martin." Cicero.

The setting sun was sinking slowly in the West. The last of its rays had nearly ceased to impinge upon the rods and cones of the retina of the observer. It lighted a lovely country view, with its undulating uplands, dotted here and there with blossom-embowered cottages redolent of cesspools, their wells filled with liquid sewage, their interesting old thatched roofs not quite innocent of bugs, and their sturdy peasantry proud of their gout and chronic rheumatic arthritis.

It shone upon the window of an old Elizabethan mansion, where stood the Squire, a type of your fine old English gentleman, gazing on the landscape before him.

It illuminated his rubicund and smiling visage with its venous stigmata, it shone upon the chalk-stones in his ears until they glistened like diamonds, upon the tortuous temporal artery, the well-marked arcus senilis, the heavily enamelled front teeth, the venerable bald head (Syph?), with its scanty locks slightly tinged with grey. Altogether he was as fine a specimen of the Uric Acid diathesis as any one could wish to see, and involuntary thoughts of colchicum and potash mounted to your brain on a first introduction.

Yes! there he stood with a bumper of Port in his hand, a hand which was shapely enough with the exception of the little finger joints which were suspiciously enlarged, and which almost made you entreat him to soak them in Lithia water on a first introduction. All at once a shade passed over his noble countenance, his face darkened, his brow clouded, he seemed to struggle with some severe internal emotion, his features were convulsed, and yet nothing had apparently happened to disturb him.—What was then the cause of all this asks the intelligent reader? Why wind on the stomach—What varying emotions are due to flatus, and how true it is that the countenance is often but the reflex of the state of the abdominal viscera. He swallowed the wine, he smiled again. Now we are sorry to say of this gentleman that although he was never exactly drunk, yet he was hardly ever precisely sober. His heart was always going about 50,000 beats or so above the normal rate, and his vascular system was generally in a lamentably over-distended condition.

Of late years intrusive fat molecules, unwelcome guests, had deposited themselves in increasing numbers between his muscular striae, and had especially formed a too intimate acquaintance with his cardiac fibres, while a contractile material held his liver in its close embrace, and endeavoured not unsuccessfully to obstruct the carrying trade of his Portal circulation. A few hæmatoidin crystals in his brain gave evidence of an attempted strike of the cerebral arteries, which had resulted in the right leg and arm leaving off work, and only gradually resuming after some months of idleness during which time they were supported by a strike levy on the rest of his system.

So from all this you may make a very fair guess, that the present state of our Pathological Papa was somewhat precarious.

The prognosis was however favourable, as he was now in the hands of a junior practitioner, who was treating him on the most scientific principles, digitalis to brace up his distended vascular system and tone down his too impulsive heart, a couple of pints of ether daily to dissolve away superfluous adiposity, iodide of potassium for any stray syph. that might be knocking about, and Vichy water for his vitiated liver, and so on.

But, exclaims the hitherto angelically-tempered reader, "how about that smile, let's have an explanation of that smile."

Certainly intelligent peruser we hate explanations, especially when our future father-in-law asks us how we are going to marry and keep a small family on £80 a year; but in this case we will favour him with one, free gratis and all for nothing. It was the sight of his daughter coming up the avenue that induced the grin; and having now by the introduction of the female element on the scene excited the curiosity of our junior readers to the highest pitch, we ought by all laws of novel-writing to leave off, but will take pity on him and won't.

Shortly then, this young lady was one of that noble band who, scalpel in hand, amputating saw on side, are now endeavouring to force the ramparts of public opinion, and break down the barriers of good taste and modesty, which now separate them from the inmost recesses of the Dissecting Room, the Operating Theatre, the Morbid Anatomy Museum, delightful and suitable places of recreation for the fair sex, and where the faculties of inquisitiveness and curiosity should at length repose satisfied.

Our heroine, for here we take her by the hand and introduce her to our readers, had received her medical education at the well-known University of Spinzsterberg, where she had graduated with great distinction as Doctor of Medicine. She had early imbibed the princples of Socialism, and after forming a temporary alliance with a young gentleman of congenial tastes, also pursuing his studies at the same Institution, had been requested by the authorities to seek change of air, principally on account of her persistence in demanding Afternoon Beer.

Being somewhat alarmed at this, she had then set seriously to work, but finding that the Dissecting Room smelt nasty, that the Operating Theatre was too hot and crowded, and the Museums too dusty, dry and solitary

she had not favoured them with much of her company, but had turned her attention to Obstetrics, in which department of science she would no doubt have succeeded admirably, had not a couple of unfortunate and fatal casualties in her first few cases somewhat prejudiced her against it.

She found, too, that a slight disturbance of her cranial circulation ending in the supine position and temporary annihilation of her faculties, was wont to take place when anything "went wrong," as the saying is.

So she was now settled in her father's native place as a general practitioner, and was a great favourite among the ladies as long as she remained unmarried, and extensively patronized by the poorer classes, until her accounts went in.

A neighbouring Homœopathist had found his business so considerably diminish, that after a vain attempt to induce her to go into partnership, both connubially and commercially, he took three bottles of his strongest tincture of Aconite, but finding they produced no effect except perhaps a slight increase of appetite for dinner, he changed his suicidal mind for an emigrating one, and disappeared from the scene, never to return. But the condition On Admission of our heroine into this veracious narrative is far more interesting than any personal history, however well worked out.

And how is it possible to portray this fairy-like Being? Consider the disadvantages under which we labour.

Instead of the Poet's pen we possess only a Stethoscope; instead of the Artist's pencil a Thermometer.

How shall we dilate upon her sympathetic aud sentimental nature (Nervous System: Emotional and unstable), her marvellous flow of Language (Tongue: rapid in action; controlling influence of higher Cerebral centre over it deficient); her lovely blue eyes (Sclerotics: pearly; Iris: dilated-Bellad.?); her ripe lips and sunlit hair.

Who shall venture to describe her finely-shaped Bust (Organs of R. and C.: Impeded in action by tight-lacing. Transverse indentation on Liver from same cause, and displacement of Uterus backwards), and her charming Grecian bend (Injurious strain on arch of Foot by high-heeled shoes).

And to think that all this is wasted on dry bones, ugly instruments, and nauseous Drugs; while the Curate, the Lawyer, the Homœopathist were all at her feet consumed by all-powerful Love; ready to sacrifice Whist, Cigars, Tobacco, Grog, all, all that makes Bachelor life endurable, if only she, their Loved one, their Ideal, the Flower of the Dissecting Room, the Goddess of the Operating Theatre, the Rose of the P. M. table, would consent to crown their wishes.

Ah! could they but imprint Kisses on those warm pouting lips, half-parted, just disclosing the Incisors and Canines within, or clasp that hand so familiar with the Speculum!

But we really cannot nndertake to produce any more of this kind of thing at the price, so we intend to describe the "Society for the Total Suppression and Absolute Prohibition of Sausage Making."

But this we really must defer until next number, and give the reader an opportunity of gratifying his curiosity and testifying his pride in his Alma Mater at same time for the small sum of sixpence.

STATISTICAL REPORT OF GUY'S LYING-IN CHARITY FOR APRIL, 1878.

Number of women attended 216

No death.

Of these there were in their	1st	confinement	32
,, ,,	2nd	,,	23
,, ,,	3rd	,,	36
,, ,,	4th	,,	35
,, ,,	5th	,,	27
,, ,,	6th	,,	13
,, ,,	7th	,,	12
,, ,,	8th	,,	11
,, ,,	9th	,,	11
,, ,,	10th	,,	6
,, ,,	11th	,,	8
,, ,,	12th	,,	1
,, ,,	13th	,,	1
			—216

Single births, 209; double births, 4; making 217 children at full time. Premature, 1; making 218 children born. Miscarriages, 2; making 220 births in all.

Of the children born there were—

Males alive	112	
Females ,, ...	101	
Males dead	1	
Females ,, ...	3	
	—217	

Operations:—

Forceps, 4; 3 low and 1 high.

Turning, 1 in Placenta Prævia, after dilatation with Barnes's bags.

There was one case of P. P. H., treated by injecting cold water into the Uterus.

Still births:—

The cause in two is not mentioned. In one there was intra uterine maceration, and in one there was a prolapse of the Funis, and artificial respiration failed to restore the child.

Presentations:—

Vertex	211	
Breech	5	
Foot...	2	
	—218	

In the 4 cases of Funis—

Vertex presented itself in both children three times.

Vertex and foot once.

Cases attended:—

Mr. Austin	52	
Mr. Bedford	52	
Mr. Cross	53	
Mr. Hide	51	
Mr. Caswell	8	
	—216	

The Presidents of the Physical Society beg to acknowledge the following contribution:—

R. N. Montefiore, £1.

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NOTES OF THE MONTH.

ON Thursday, 9th ult, Mr. W. D. Hartley sailed for the Cape, having taken the appointment of Surgeon to the troops now serving there against the Kaffirs, and on the 17th he was followed by Messrs. Birdwood, Giles Mansell, Reynolds and Instone, who also went out as Surgeons. We hope in a future number to be able to publish an account of their experiences. They were all expecting to be sent on active service and had signed agreements to remain for one year, or until the end of the war. We should be much obliged to any of their correspondents for news of our adventurous friends.

THE following gentlemen passed their primary examination for the Fellowship at the College of Surgeons during the month of May:—Messrs. Charles Atkin, Henry T. Basset, James T. Brett.

The following gentlemen passed their primary examinations in Anatomy and Physiology during the months of April or May:—Messrs. Challoner Clay, M. D'Oyley Gilkes, Augustus P. Hills, Frederick M. G. Smith, Percy H. Gardner, James Anderson, John M. Owen, J. Winthrop Woodruff, Harold D. Davenport, John Rigby, Frederic W. Pilkington, Benjamin H. Mane, John J. Boswell, Leopold Burroughs, Hugh P. Rowlands· Robert A. Milligan, Harry P. Berry, Joseph J. Udale, John R. Rolston, N. E. Johnson Gaylor, Arthur S. Stokes, W. Cecil Fenwick, A. Carrol Otway, Henry E. Archer, George J. Wilson, Joseph M. Prendergast, Oswald J. Currie, T. F. B. Palmer, E. R. Drummond Fasken, Edgar Elliot, Wm. H. Crosse, W. Eckett Fielden, T. R. Marsh, W. W. Pryn, F. H. Shaw, B. Studer, T. W. Beales, L. W. K. Phillips, R. J. H. Scott, D. C. Trott, H. G. Ashwell, J. W. Sanders, E. A. Starling, W. W. David, W. C. Hearnden, H. W. Campbell.

THE following gentlemen were admitted members of the College during the same period:— Messrs. Alfred Burt, Frederick H. Berry, Alfred St. C. Buxton, William W. Pinching, J. H. Barnard, George Davis, Augustus E. Morton, Henry O. Stuart, George J. W. Flower, George W. Butler, Frederick W. Apthorp, Edward T. Crouch, Howard Hawkins, B. F. Giles, P. F. Gilbert.

APOTHECARIES' HALL.—The following gentlemen have passed their examination in the science and practice of medicine, and received their certificates to practice:—Messrs. Evan Maunton Davies, Joshua King Womersley.

AN ENTHUSIASTIC OPERATOR.—Surgeon Cox was an enthusiastic and eccentric Army-surgeon in the late war. After the battle of Antietam he essayed the amputation of the mangled limb of a soldier, and became so absorbed in his task that he did not notice that the man was dying. As he began sewing up the stump, a hospital steward who chanced to pass said, "Doctor, there is no use going on; the man is dead." The surgeon looked up in surprise, and then said, "I am sorry the poor fellow is dead; but there is one consolation about the matter, he has gone to heaven with a 'flap' he may be proud of."—*New York Medical Record.*

INFLUENCE OF THE PIANO IN AFFECTIONS OF THE UTERUS.—Dr. Balestre terminates an article which he has published in the *Nice Medical* by saying that his meaning would be misunderstood if it were thought that he discountenanced music as a part of female education, or that he believed it to be the origin of uterine ailments. All he wishes to enforce is what has demonstrated to him:—that in very nervous and impressionable women who are suffering from affections of the uterus, music may provoke and aggravate congestions of this organ, and that in advising the patient concerning her hygienic management this fact should be borne in mind. Moderation in the practice of music, and interuptions in its pursuit must be insisted upon while pursuing the ordinary measures of treatment; and by this means various accidents occurring during uterine affections will be obviated.—*Medical Review.*

THE question of the best form of treatment of the apparently drowned is still undecided. That of Marshall Hall found to be convenient and successful when first adopted was after a time superseded by the Sylvester method, and the latter was adopted by the Royal Humane Society as the best that could be put into practice by an unskilled bystander. The method recently recommended by Dr. Howard of New York appeared to be an improvement upon either of the above methods (*see Guy's Hospital Gazette* Ap. '78), but from the force with which the contents of the stomach are ejected, and the great pressure exerted on the chest and abdomen, it is believed that this might not be always a safe mode of proceeding; specially in the hands of an inexperienced person. The question is also raised whether the repetition of jerkey movements in this process may not diminish the chances of recovery, so that the method is believed by many not to be faultless. A committee of investigation has been appointed to test this method, compare it with others and finally select the best mode of inducing artificial respiration from the several processes extant, and their decision will probably determine the process which will be adopted in this country for many years.

MR. A. ROSS, M.R.C.S.E., L.S.A.L. has been appointed House Surgeon and Secretary to the West Sussex, East Hants, and Chichester General Infirmary and Dispensary.

Just published, crown 8vo. 5s.

A MANUAL of NECROSCOPY; or a Guide to the Performance of Post-Mortem Examinations. Notes on the Morbid Appearances and Suggestions for Medico-Legal Examinations. For the use of Students and Practitioners. By A. H. NEWTH, M.D.

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GUY'S HOSPITAL GAZETTE,
JULY, 1878.

CEREBRAL LOCALISATION.

It is not intended in the present article to discuss Psychology in any of its bearings, but rather the relation between certain combined and definite movements on the one hand, or sensation on the other, and physiological change in a corresponding portion of the cerebral convolutions. Thus the idea of Coste that the position of the soul was in the Pineal gland, which gained credence until it was found that the said Conarium might be destroyed or affected with calcareous degeneration without the soul being more earthy in consequence, will not be considered. Neither will that of Gall and Spurzheim, according to which the mental qualities might be recognised by examination of the external surface of the skull, and which has given rise to the doctrine of Phrenology. According to these observers, different portions of the brain are devoted to different mental qualities which are developed in a degree proportional to the size of the part on which they depend. The external surface of the skull being believed to correspond in form with that of the brain, the character of each individual was supposed to be clearly discernible by an examination of the head. This was, therefore, as Spurzheim defined it—"the doctrine of the special faculties of the mind," or, psychological, and will not, therefore, be discussed in this article.

It is rather the question whether contraction in one muscle or group of muscles depends on physiological change in a part or the whole of a specific cerebral convolution, and whether sensation is similarly due to localised brain change, and the arguments upon which such an idea is founded which will be now discussed.

Dr. Ferrier states that the organic memory of sensory impressions is the fundamental basis of knowledge, quoting the assertion of Aristotle,—"Nihil est in intellectu quod non prius fuerit in sensu." However this may be, that motion at any rate frequently depends on sensation, may be looked upon as an acknowledged and undoubted fact. Thus Dr. Foster tells us in his "Text book of Physiology."

"For every bodily movement of any complexity afferent impulses are as essential as the executive efferent impulses. Thus the movements of the eye are dependent on vision, and every ball room affords abundant evidence of the ties between sensations of sound and motions of the limbs. Every bodily movement may almost be considered as a reflex action made up of afferent and efferent impulses and central actions, and set going by the influence of some dominant afferent impulse, or by the direct action of the will on the centre itself. All day long afferent impulses from eye, ear, skin and muscle are streaming into our nervous system, and did each afferent impulse issue as its correlative efferent motox impulse, our life would be a prolonged convulsion. As it is by the checks and counter-checks of cerebral and spinal activities, the impulses are drilled and marshalled and kept in hand in orderly array till a movement is called for, and thus we are able to execute at will the more complex bodily manœuvres, knowing only why, and unconscious, or dimly conscious, how we carry them out."

Movements may be volitional, involving, it is supposed, conscious discrimination in the motor centres of the cerebral cortex, and paralysed by their destruction, or automatic, such as those concerned in equilibration, locomotor co-ordination, &c., which seem to be presided over by centres situated below the cortex. It is the former which have been specially studied by Hitzig, Ferrier, and others, Dr. Ferrier having definitely localised many of the motor centres presiding over the different movements, or groups of movements, produced volitionally,

In the case of *common sensation* the following would seem to take place when a movement occurs dependent on an afferent impulse starting from the peripheral extremity of a sensory nerve connected with the spinal cord. From the point where the impression is produced the afferent impulse passes along the sensory fibres of the nerve (probably the Axis Cylinders) at the rate of 133 feet per second, into the posterior cornea of the grey matter of the spinal cord. Crossing at once to the opposite side, it then extends upwards along the grey matter of the cord until it reaches the medulla oblongata where the sensory track divides into two halves, which pass upwards on the outer side of the now superficial motor nuclei of the bulb. It then extends upwards along the back of the Pons Varolii, through the upper and posterior fibres (tegmentum) of the coura Cerebri, and through the posterior division of the internal Capsule,* into, as Dr. Ferrier supposes the Hippocampal region, a term applied by him to the Hippocampus Major or Cornu Ammonis and uncinate convolution conjointly, since he was unable to determine their separate functions. M. Pitres on the other hand believes the sensory fibres to spread themselves over the whole Occipitosphenoidal region of the brain. However this may be, the impulse would seem to pass from the sensory region as influenced by the effects of congenital propensity,

* Internal Capsule is a name given to the expansion of the Corus Cerebri or foot of the Corona Radiata of which the anterior two thirds containing the motor track pass between the Candate and Lenticular nuclei of the Corpus Striatum, while the posterior third containing the sensory tract lies on the outer side of the Optic Thalamus.

education, habit, &c., to some definite portion of the surface of the cerebral convolutions belonging to the motor regions of the brain (Bases of three frontal convolutions, ascending frontal and parietal convolutions, superior parietal convolution, together with the internal aspect of the same). In the nerve cells of this portion of the brain the potential is converted into kinetic or actual energy, the effect of the afferent impulse being perhaps, as Dr. Carpenter suggested, a local Hyperæmia producing increased tension of the nerve centres, which will show itself in muscular movement, and which is due to the action of the Vasomotor system of nerves on the muscular walls of the arteries. This period of transformation of the afferent into efferent impulse by mental action occupies from $\frac{1}{10}$th to $\frac{9}{10}$ths of a second, being termed the reaction period, permanent molecular change being supposed to take place in the nerve cells of the cerebral cortex forming the basis of memory, and thns the memory of events, that is, the effect produced by events on the cells of the cerebral cortex may be localised in the same way as other functions of the brain are supposed to be. Dr. Ferrier believes this organic register of sensory impressions to be anatomically distinct from that of movements. Dr. Prout, again, states that in the employment of the brain some chemical action probably occurs leading to decomposition of neurine as shown by the increased amount of phosphates in the urine of those given to excessive brain work, neurine containing 1 per cent, of phosphorus. Dr. Paton, however, states this to be untrue.

By the action of the will the efferent impulse is now sent along a definite line to the corpus striatum (by means of which muscular movements seem to be co-ordinated), and along the anterior two thirds of the internal capsule, placed between the candate and lenticular nuclei of the corpus striatum, through the lower or superficial portion (crusta) of the crus cerebri, and anterior portion of the Pons into the medulla oblongata. The efferent motor fibres at the anterior aspect of the lower extremity of the bulb cross to the opposite side and pass downwards along the anterior and lateral white columns of the cord. Exceptionally it seems that this decussation does not occur, as in a case described by Pierret, and it is in this way that the occurrence of paralysis on the same side as the cerebral lesion, which has undoubtedly happened, seems to be best explained.

The sense of smell is due to the matters of odour being dissolved in the mucus of the Schneiderian membrane, and influencing the filaments of the olfactory nerve, along which the afferent impulse passes through the cribriform foramina of the Ethmoid bone to the olfactory bulb. Thence it passes along the olfactory tract to the anterior perforated spot where the three roots of the nerve unite. Thence along the external or long root it passes outwards towards the fissure of Sylvius, and to the tip of the Temporosphenoidal lobe or Subiculum Cornu Ammonis (which is subjacent to the Cornu Ammonis or Hippocampus major). Dr. Ferrier believes that the sensory impulse passing along this root excites the sense of smell, the subiculum Cornu Ammonis being believed by him to be the olfactory centre. Both the middle and inner roots which arise from the Frontal lobe contain fibres said to be connected with the Corpus striatum, and Dr. Ferrier suggests that these may pass to the opposite hemisphere with the other sensory tracts. The occurrence of loss of smell on the same side as cerebral Hemianæsthesia, viz.: on the side opposite the cerebral lesion would be thus more satisfactorily explained than by attributing it to the co-existence of Anæsthesia on the same side, though Majendie has demonstrated that the sense of smell is lost when the sensibility of the nostril is abolished by division of the sensory branches of the 5th nerve.

Taste is due to the effect produced by dissolved sapid matters on the branches of the Lingual branch of the 5th nerve (superior surface of the anterior and lateral parts of the tongue), and of the Glossopharyngeal nerve (posterior and posterolateral parts). By means of these nerves the afferent impulse would extend to the Pons Varolii and floor of the fourth ventricle where it would join the other sensory tracts and pass upwards to the lower part of the middle Temporosphenoidal convolution, where Dr. Ferrier believes the centre of taste to be in immediate relation to that of smell.

In the case of *vision* when the image has formed on the Retina the sensory impulse extends along the optic nerve to the Chiasma, the inner fibres of the nerve returning along its anterior border to the optic nerve of the opposite side, the central fibres decussating and passing into the opposite Optic Tract while the outer fibres join the Optic Tract on the same side. The Optic Tract therefore contains fibres connected with both Retinœ, and these pass through the Corpora geniculata into the Corpora Quadrigemina and thence according to Ferrier to the angular gyrus. Destruction of the angular gyrus on one side causes blindness in the opposite eye, without that on the same side being in any way affected. It would seem therefore probable either that there is total decussation of the Optic nerves in the Chiasma, as Dr. Bastian believes, or as seems more probable, that while the central fibres decussate in the Chiasma, the outer fibres do so in the Corpora Quadrigemina, as Charcot suggests, so as to reach the angnlar gyrus of the opposite hemisphere, this being as Dr. Ferrier supposes, the centre of vision.

In *hearing* the impression is produced on the cochlear and vestibular terminations of the Auditory nerve

by extension of the sonorous vibrations to the fluid of the Labyrinth. The sensory impulse extends thence along the Auditory nerve to the floor of the 4th ventricle, and then along the fibres of that nerve which join the restiform body to the cerebellum. It is thus, according to Dr. Ferrier, that Labyrinthine conjointly with tactile and visual impressions constitute the afferent agents by means of which the Cerebellum effects locomotor co-ordination, as will be further explained in speaking of that part. Since his experiments indicate that the Superior Temporosphenoidal convolution is the centre of auditory sensation, and the sense of hearing is usually unaffected when animals are deprived of their cerebellum, he thinks it improbable that all the fibres of the nerve thus terminate, and it would seem, either that some of the auditory fibres leave the cerebellum again by the superior peduncles and valve of Vieussens, or as is more probable that some fibres instead of entering the cerebellum ascend with those fibres of the posterior pyramids which quit the restiform bodies to pass up to the cerebellum.

That the different functions of the Brain are localised in special regions of the cerebral hemispheres is not a new idea. Coste on the one hand, and Gall and Spurzheim on the other, originated different views with respect to such localisation, as already stated, while, Sancerotte, Bouillaud, Foville and others believed the fact, Foville thinking that distinct motor centres exist in the cerebrum. Flourens finding that a large part of the cerebral hemispheres might be destroyed without their functions being lost, through removal or destruction of the whole, produced complete extinction of all their properties, supposed that the brain acted as a whole without any localisation of its functions. Hughlings Jackson first indicated the motor functions of certain regions, explaining thus unilateral convulsions, and how they might be dependent on a local cause, and Dr. Wilks more than twenty years ago, explained the existence of convulsions without loss of consciousness, as follows ,— "In these cases the causes being definite and local an irritation is set up in the corresponding ganglia beneath, and thus the occurrence of convulsions without loss of consciousness is explained."

Both by experiments and pathological research a new light has been recently thrown upon this interesting subject, Dr. Ferrier having specially thus investigated it.

Dr. Ferrier's researches were made by the localised application of the interrupted current of an induction coil (faradization) to different parts of the brain, the animal having been first rendered insensible by chloroform, that the movements excited might undoubtedly be due to the physical changes thus induced. The current was usually not stronger than could be borne without discomfort on the tip of the tongue, no electrolytic decomposition of the brain substance being thus produced, as was the case in the experiments of Fritsch and Hitzig who made use of the current of a galvanic pile. It was found that while certain regions of the brain gave no response to electric stimulation however strong (antero frontal and occipital regions) the stimulation of others gave rise to definite and predictable localised movements, some degree of Hyperæmia being alone produced in the region stimulated and no decomposition of brain substance as when the galvanic current is applied. This would seem to render Dr. Carpenter's suggestion more probable, that muscular movements are due to localised Hyperæmia, the oxygenation of the nerve tissue by the blood converting its potential in to actual energy.

Objections have been made to the conclusions drawn by Dr. Ferrier from his experiments :—

1.—That the brain is insensible to electrical irritation (Longet, &c.) disproved by Fritsch and Hitzig.

2.—That the effects were but temporary, as stated by Goltz, who after washing away portions of the surface of the brain with water described the effects as not being permanent.

3.—That the effects were really due to conduction of the currents to the ganglia at the base of the brain, the existence of such conduction through the brain being an established fact.

These are discussed at length by Dr. Foster in his "Text book of Physiology," and by Dr. Ferrier in his work on the functions of the brain; the third objection being chiefly reputed by the fact that cerebral lesions paralyse the same muscles as are moved when the same part of the brain is stimulated.

The experiments where first made on the brains of jackals, cats, dogs, &c., definite movements being produced, and the results being as accordant as could be expected, and lastly on Macacque Monkeys (Baboons) in which the arrangement of the convolutions corresponds more nearly with those of the human brain. Stimulation of different parts in the motor region was found to produce movement in the corresponding muscles of the body, and the grey matter of the cortex being removed, stimulation of the denuded medullary fibres between the Cortex and Corpus Striatum was found by Dr. Burdon Sanderson to cause the same definite action as before. Thus stimulation of successive fresh surfaces of the wedge of brain substance whose base corresponded to the particular superficial motor area, and the apex to a point in the Corpus Striatum, produced similar effects, the movements being most distinct when the corpus striatum itself was irritated. The inference was obvious, that while volitional movements are directed by a specific motor area in a localised portion of the Cortex, the motor impulse is thence conveyed along the radiating fibres to the corpus striatum by which it is transmitted to the cerebral or spinal nuclei which govern the movements of the muscles which are to act. Patho-

logical evidence has more or less confirmed this idea.

Dr. Ferrier's experiments on animals, the conclusions which he derives from them, and the pathological evidence of their meaning, were so fully described in his work on "The functions of the Brain," and in the Goulstonian lectures recently delivered by him at the Royal College of Physicians, that it will be unnecessary to do more than briefly mention them, and the conclusions at which he arrives in consequence.

ANTEROFRONTAL REGIONS OF THE BRAIN.

Electrical irritation of the convolutions belonging to this region, namely those situated in front of the coronal suture, (superior or 1st, middle or 2nd, and inferior or 3rd frontal convolutions) produced in monkeys negative results, as far as the sensory faculties, taste, sight, hearing or touch were concerned, neither, with one exception, were the motor faculties in any way affected. The exception mentioned is the fact that stimulation of the posterior half of the superior and middle frontal convolutions produced movements looked upon by Ferrier as the outward manifestations of subjective auditory sensation (wide opening of the eyes, dilatation of the pupils, and turning of the head and eyes towards the opposite side). These movements, with one exception (the absence of pricking of the ears) being the same as those produced by stimulation of the superior Temporosphenoidal convolotion which is believed by him to contain the centre of hearing, seemed to indicate that the action of these two parts may be associated. Destruction of the frontal lobes produced neither sensory nor motor paralysis. The only change produced by electric stimulation appeared to be in character and behaviour, the animals seeming less intelligent and to have lost the faculty of attentive observation. The "American crow bar case" in which a bar of iron passing from below the left angle of the jaw, through the anterior part of the left hemisphere produced in the patient no symptoms indicating that the motor or sensory faculties were affected, but mental change which was evident to his friends and acquaintances also indicates the connection of this region with mental activity, rather than with sensation or motion.

Dr. Ferrier quotes other cases in which injury or softening have produced neither sensory nor motor paralysis while in some the altered mental condition and state of hebetude have specially attracted notice. He also notices the frequent connection between mental deficiency and arrested development or atrophy of the frontal lobes, as in a case of congenital idiocy described by Cruveilhier in which the anterior two thirds of the frontal lobes were completely wasting.

Aphasia, or rather a variety of Aphasia exists, of such a nature that though the motor nerves of the organs of speech are free from paralysis, the co-ordinating centre of the muscles employed in a healthy state, and the intellect but slightly if at all impaired, the patient affected with it cannot recollect the words requisite to express his thoughts or arrange them in a proper manner. This condition is now generally acknowledged as due to some lesion in the posterior portion of the 3rd left frontal convolution, where it is adjacent to the fissure of Silvius, and overlaps the island of Reil, as was shown by the French surgeon, M. Broca.

Dr. Ferrier found thatin monkeys stimulation of the inferior extremity of the ascending frontal convolution opposite the posterior ter mination of the 3rd frontal convolution produced:— "opening of the mouth with protrusion and retraction of the tongue" viz., the outward manifestations of speech, and this region is believed by him to contain the motor centres of articulation in those animals.

Speech may perhaps be looked upon as composed of four different processes:—

1.—The mental process or idea to be expressed in words.

2.—The selection and arrangement of the words by which the idea is to be expressed (3rd left frontal convolution).

3.—The co-ordination of the muscular movements by which articulate speech is effected (Corpus Striatum).

4.—Employment of the muscles by means of which the necessary words are uttered.

It is the second process which is believed to take place in the posterior portion of the 3rd or inferior left frontal convolution (exceptionally in the same convolution on the right side as in left handed person), and in most cases right hemiplegia co-exists. This is owing to the usual cause being obstruction of the left middle cerebral artery, which supplies not only anterior and middle lobes of the brain, but also gives branches passing through the anterior perforated spot to the lenticular, and candate nuclei of the Corpus Striatum, the internal capsule and anterior portion of the Optic Thalamus. The immediate cause of the obstruction in most cases is embolism, consequent on rheumatic inflammation of the valves of the heart, Thrombosis due to the calcareous or atheromatous degeneration of old age, or to the yellowish thickening of the coats which occurs in syphilis.

Stimulation of the inferior frontal, or of the orbital regions, or of the island of Reil, in monkeys produced negative results.

MOTOR REGIONS.

ASCENDING FRONTAL AND PARIETAL CONVOLUTIONS.—SUPERIOR PARIETAL CONVOLUIONS.—PRÆCENTRAL LOBULE.

A general lesion of the above convolutions in the monkey was found to produce complete hemiplegia of the opposite side, exactly resembling that due to a lesion in the Corpus Striatum or other part of the motor tract, and perhaps followed by the same secondary degeneration, extending through the Crus,

Pons, &c., and the consequent late rigidity. General destructive lesions (caseous degeneration, yellow softening &c.,) in the same regions in man have also been known to produce permanent hemiplegia, often followed in the same way by secondary degeneration. Partial lesions in these parts have at times had the same effect, the lower two-thirds of the left ascending Parietal convolution being alone affected in one case, and the præcentral lobule (inner aspect of the above convolutions) with part of the ascending frontal convolution in another.

Irritation of the different parts in these regions was found to produce in monkeys some definite and localised movement. Thus irritation of the posterior half of the superior and middle frontal convolutions caused the eyes to open widely, while there was conjugate deviation of the eyes and turning of the head towards the opposite side, as already indicated, Ferrier attributing the latter movements to the unantagonised action of the centre on the opposite side. Irritation of the ascending frontal convolution at its upper part caused extension of the head and arm, and lower down supination and flexion of the forearm, lower still movements of the Zygomatici and muscles depressing the lower lip, and at its lower extremity opening of the mouth with protrusion and retraction of the tongue as mentioned above.

Irritation of the upper part of the ascending parietal convolution and adjoining part of the ascending frontal convolution produced conplex movements of the thigh, leg and foot, with adapted movements of the trunk, lower down movements of the tail, and farther back and lower still stimulation of the ascending parietal convolution produced different individual or combined movements of the fingers and wrist.

Irritation of the superior Parietal lobule produced flexion of the foot, and often flexion of the thigh and extension of the leg forward as in walking.

In the Goulstonian lectures Dr. Ferrier alluded to several cases in which lesions in the above part produced paralysis of the same muscles as were moved when the parts were irritated.

Thus in two cases of crural monoplegia (paralysis of a group of muscles) the upper part of the ascending parietal convolution was found to be injured, or diseased, while cases of brachiocrural monoplegia were mentioned in which the lesion was found at the upper extremity of the fissure of Rolando. Cases of brachial monoplegia were also recorded in which the opposite ascending parietal convolution was diseased in the part which had seemed to preside over the movements of the paralysed muscles.

Amputation of the arm, has been also connected with atrophy in the ascending frontal, and arrested development in the leg with atrophy in the ascending parietal convolution.

Cases of Brachiofacial monoplegia were also mentioned in which the lesion was found in the lower part of the ascending frontal and parietal convolution where the centres of the different facial and brachial movements are adjacent. MONTAGU LUBBOCK.

(To be continued.)

BACTERIA IN PYÆMIC BLOOD.

The following is a short account of a microscopic examination of the blood of a well marked pyæmic case, resulting in the finding of bacteria.

As to the case itself, an extremely interesting one, it is intended to publish a fuller report of it at some other time.

An examination of the blood in the ordinary way was made just after the appearance of a second metastatic abscess (superficial in character), when bacteria of three different forms were undoubtedly present exhibiting active movements in the blood.

The second examination was conducted with greater precaution. The patient's finger was thoroughly cleansed by washing with Carbolic lotion (1-20), the slides and covers were steeped in strong H_2SO_4 and then washed in fresh distilled water, a clean carbolized needle being used.

An examination was afterwads made in conjunction with Dr. Greenfield, who, as a member of the Pyæmic Committee of the Pathological Society, came specially to see the case. The same precautions were taken as to the cleanliness of the slides, covers, &c., but the blood was taken from the lobe of the ear which was first cleansed with absolute alcohol.

It may be well to state that this examination was made two or three days after a third metastatic abscess had been opened.

Another examination was made in a similar way by myself.

In all the examinations bacteria were found; as to the forms, the free bacterium termo was most commonly met with (small dumbbells); angular bodies with bulgings or nobs at the angle and at each end were also seen; these were perhaps a larger kind of bacterium termo. Straight moniliform bodies were also seen (vibrio), and a peculiar form, larger than the previous ones, very much like the bacterium No. II., described by Professor Lister in his article on "Bacteria and the germ theory," in volume XIII. of the *Quarterly Journal of Microscopical Science*, vide. plate XIX. illustrating the paper bacterium No. 2 in urine. See also plate V in same journal, illustrating Cohn's memoir on bacteria, figure 8 for bacterium termo, of which as many as 5 and 6 were counted in the field of the microscope at the last examination of the blood.

Further examination of the blood will be made if possible, both by the warm stage and also by Hœmocytometer. G. F. CROOKE.

P.S.—The lenses employed were $\frac{1}{12}$ immersion by Ross, and Nos. 9 and 10 a l'immersion of Hartnach's, all very fine lenses.

GUY'S HOSPITAL GAZETTE,

JULY, 1878.

WHATEVER may be said for or against the "moderate" use of alcoholic stimulants, there can be no two opinions as to the evil effect of their excessive employment. Bearing this in mind, we cannot but express our gratification at the fact that a measure, entitled "The Habitual Drunkard's Bill," has been read a second time in the House of Commons, and hope that in spite of the crowded state of public business it may become law this present Session. However tentative and crude the Act may be, yet it is an attempt to grapple with a great and universally acknowledged evil, and any effort in this direction is better than none at all. The difficulty of the measure rests in the dangerous amount of power which such an Act, if compulsory, would place in the hands of unscrupulous persons. Does drunkenness in time amount to a mania? and have habitual drunkards lost the power of self control? Doubtless, this is the case in many instances; but, on the other hand, if these persons are cut off from the use of alcohol, they become as sane as other men. The Bill, as read, is without compulsory clauses, and is simply "permissive," that is, it allows the establishmeut of places in which persons who feel themselves unable to fight against their alcoholic craving may voluntarily enter, such places to be under proper Government inspection, and it is compulsory in so far as it seeks to exercise the power of retaining such persons until they may be cured of their evil habit. It was pointed out that one great blot against the measure would lie in the fact that habitual drunkards are usually found amongst the poorer classes, who would be unable to pay the necessary fees for their maintenance in the institutions proposed to be established. It is a matter for grave consideration whether the community at large should be taxed to maintain persons who should be looked upon rather in the light of offenders against society than of those who have not the power of controlling their animal instincts. Bnt we cannot but think that this is a difficulty which some of the immense funds of the United Kingdom Alliance, which are annually wasted over the abortive Permissive Bill, might be called on to meet. Our interest lies in the medical aspect of the matter, although we cannot fail to have forced upon us how great a part in the community at large the drunkard plays. We cannot think we are guilty of exaggeration in saying that half the beds in our—or any other—hospital are filled by patients who directly or indirectly are brought there by the excessive use of alcohol. This seems to us a good reason why we should welcome such an attempt as this measure now passing through Parliament; objections and difficulties might be found, doubtless, without number, but as we have said, anything that serves to abate, no matter in how small a degree, a great and crying social evil should be welcomed, so long as it does not interfere with the personal liberty of the subject.

ONCE more we have to congratulate ourselves and our athletes, for Guy's is again the Champion Hospital. The Challenge Shield is our property for another year, and as the men to whose prowess we are indebted for it are of the junior years, we have good prospects for time to come. Guy's was *facile princeps* with five firsts, to say nothing of the consolation first. Of course, in a competition like this the large hospitals have a great advantage over the smaller ones, and this was strikingly seen in the contest this year. We would commend this point to the attention of those who have the direction of the sports. Could not something be done in the way of amalgamation of the smaller schools? It would, of course, be said that this would destroy *esprit de corps*, but then this might be obviated by allowing the winning group of small schools to run the events off between themselves. We throw this out as a suggestion, because we think it can scarcely be maintained that a hospital with an annual entry of 30 is on fair terms with one of 100.

MARRIED.—On the 16th May, at the Parish Church, Oystermouth, by the Rev. S. C. Morgan, Vicar of Swansea, R.D., J. Farrant Fry, fourth son of the late William Fry, Esq., of Portfield, Somersetshire, to Constance Mary, eldest daughter of John Gaskoin, Esq., of Longfield, Oystermouth, Glamorganshire.

INTERSTITIAL NEPHRITIS.

By T. S. SHELDON.

PAPER READ BEFORE THE PHYSICAL SOCIETY, MARCH 23RD, 1878.

This disease possesses great interest, for this reason:—That it is so beset with roughnesses as to render approach difficult, and smoothness of contour, a feature only to be acquired by future attrition. That which is easy of attainment charms less than that which has to be arduously striven for; the sinuous path and rugged mountain summit number more admirers than the grassy plain and well-trodden road.

If other reasons were wanting to make the study of chronic Bright's disease more interesting to us, it would be this:—That the untiring energy and acute observation of one of the choicest of Guy's physicians threw the first and clearest light on this complex morbid condition.

Whilst reading Dr. Bright's papers on renal disease I was surprised to find how little essential advance we had made beyond him; much of our present theorising is but the more detailed expression of his surmises, and as for treatment, I may quote from Mr. Davy's commentaries for the Gurney Hoare prize:—"The cases which he cured, we cure now; the cases which he lost, are as hopeless now as then." And we must admit the justice of this sentence, which is further borne out by Dr. Dickinson's interesting summary of the treatment of Acute Nephritis by different physicians (Albuminuria, p. 113).

On the threshold of my subject I am obliged to be controversial; indeed, I may at once express the opinion developed during the collection of material for this paper, that chronic Bright's disease and controversy are convertible terms, and that of all the products of observation and theory, or pathological apples of discord, none is more hydra-headed, none more hotly contested for than this—the theme of this evening.

So much importance is there attributed to a name in our day, that it may fairly be said the controversy alluded to turns on the question—What shall we call this disease, of which a chronic and peculiar wasting of the kidney structure is the prominent feature?

Chronic Bright's disease is a sufficiently harmless designation, if all used it in the same sense; but while some call the large white and fatty kidney Chronic Bright's disease, others, like Dr. Moxon, say the typical and proper Chronic Bright's disease is granular kidney, and Dr. Bristowe shows no favour to any of four forms of chronic albuminuria, distinguishing them simply by their anatomical characteristics; moreover, if it be desirable, and I think it is, that a name alone teach us something of the morbid condition which owns it, then the term Chronic Bright's disease is worthless. For the remainder, the nomenclature of the disease is so intimately connected with its pathology that a consideration of the latter is necessary to understand the former.

The naked eye appearance of granular kidney is thus described by Drs. Wilks and Moxon:—"They may be reduced in size until they weigh 1½ ounces. We generally find the kidney much smaller than natural, and with its capsule thickened and adherent. The surface not smooth, but on removal of the capsule seen to be irregular and minutely nodulated with small projections, which are now referred to in the title "granular" applied to the kidney. The general figure of the kidney is retained, but numerous irregularities of surface much deface its form. Its colour in a typical uncomplicated case, that has given no symptoms during life, is often not different from that of a healthy kidney, but it may be finely mingled with whitish or greyish, or yellowish-white, through lodgment of fat in the tubules. . . . . Section shows the cortex to be thinner than natural, it may be extremely thin; it is not only thin, but its structure is seen to be confused or lost, so that the natural radiating striated appearance is not perceivable, or is evidently destroyed; minute cysts may be seen in it more or less numerous. The masses of the cortical tissue between the pyramids are less wasted; pyramids themselves are not wasted at all." The "granulations," so called, are still pervious, or at all events turgid tubules, with their contents, and constitute the best part of the organ.

Notwithstanding the remarkable naked-eye characters of a granular kidney, there is still uncertainty as to the beginnings of the disease, and it does not appear that we can yet satisfactorily answer the question.

Is the process which results in granulation of the surface and contraction of the cortex always and essentially chronic? There can be no doubt that in the large majority of cases the process *is* chronic, revealing itself only by symptoms when the disease is far advanced; it is also indisputable that a lardaceous kidney may also become granular, opinions differing, however, as to the way in which the change comes about. Rindfleisch supposes that the obstruction to the passage of blood through the glomeruli determines a collateral hyperæmia of the cortex, and so paves the way for the corpuscular overgrowth which ensues, either directly, or in consequence of some superadded inflammatory irritant.

But whether the natural history of Acute Bright's disease includes a granular kidney, such as described or not, is a question not yet decisively answered.

Drs. Wilks and Moxon say, "The possibility of this cannot be denied, but we have never met with any proofs of its occurrence.

Rindfleisch says, "Owing to the great similarity of the naked-eye characters presented by a kidney in the first stage of a purely Interstitial Nephritis, to those exhibited in parenchymatous inflammation, the two forms have often been confounded; hence the notion of a continuous morbid process, beginning with parenchymatous swelling and terminating in contraction." He then goes on to say that he does not question the possibility of such a process.

Bristowe is more bold than either of the previous authorities, and is of opinion that "there can be little doubt that the acutely inflamed organ may pass into the smooth white kindey, that this may after a time undergo fatty change, and that ultimately the degenerated tissues may waste, the fat become more or less completely removed by absorption, and the contracted granular kidney ensue."

Dr. Johnson formally describes a third stage, in which the large white kidney becomes contracted and granular, in fact, from his description, identical with the atrophied organ, which is acknowledged chronic from its commencement.

In investigating the origin of a given case one thing seems evident—if the disease began as acute epithelial nephritis—the clinical history would correspond, and this we rarely find.

Dr. Dickinson gives details of two apparently trustworthy cases of the kind.

Again, it happens sometimes that Acute Nephritis becomes grafted on to the chronic disease, a form of kidney resulting, which some have regarded as traditional: it need hardly be said that careful microscopical examination will demonstrate the incorrectness of such a conclusion. The subject is complicated by immense difference of opinion as to the pathological histology of a granular kidney, *e.g.*:—

Dr. Bristowe, in the opinion I have quoted, distinctly states the atrophic theory of the disease, which rejects the idea of intertubular changes. In his description of the process by which ordinarily a granular kidney is formed, he strongly advocates the theory of a new intertubular growth. According to his showing, then, there is no resemblance between the two pathological histories, and

granting his views to be correct, it is remarkable, to say the least of it, that the resultants should be identical.

Dr. Johnson, who like Dr. Bristowe, says the granular contracted kidney may be either the end of Acute Bright's disease or chronic from its commencement, is more consistent; indeed, after reading the account given in his published lectures, it seemed to me that the differences between the morbid processes consist simply in the intensity with which parts of them are carried out. In both cases changes in the Epithelium are described as essential; in the one case these changes are in point of time: firstly, distinctly and acutely inflammatory; secondly, distinctly degeneration; in the other case the two stages may be regarded as having altered their proportions, degeneration outstripping inflammation. The one is "Acute Degeneration Nephritis," the other, "Chronic Degeneration Nephritis," or to use a rather lame afterthought, "Chronic Degeneration Disease," a name which does not require belief in any inflammatory stage. Here the harmony is not disturbed by inconvenient intertubular changes. If one must express an opinion on the subject, the following seems to be justifiable:—I am not inclined to deny the possibility of a large white kidney shrinking somewhat and becoming rough on the surface, but that it will ever answer to the description quoted in the beginning of this paper I do not believe probable. Those cases which, so far as is ascertainable, began clinically as Acute Nephritis, are much more reasonably explained by an observation by Dr. Dickinson and others, that in some, if not in all, cases of acute parenchymatous nephritis there is a coincident interstitial increase of tissue.

I have already anticipated theories based on the microscopical appearances. A section of the wasted cortex of a good specimen is found to consist of a large quantity of connective tissue, in which are embedded the remains of the specific glandular elements, more or less altered.

The Malpighian bodies are much diminished in size, their capsules are thickened, and their capillary tufts welded into almost homogeneous lumps.

The tubes suffer in two ways, shrivelling so as to be almost indistinguishable from the surrounding tissue, or dilating. They may be crowded and opaque, with disintegrated epithelium. Some are devoid of a cellular lining, and, according to Dr. Johnson, there are always a few lined by transparent uninucleated cells, and bearing a special relationship to the cysts with which they are usually associated. Here and there tubes may be seen filled with fibrin, which during life have appeared in the urine as hyaline casts.

Commonly connected with these tubular changes is the presence of cysts, which may be of microscopic dimensions, or so large that the kidney during life forms a prominent tumour. The last good example that I have seen was in a case of general paralysis of the insane, one of the kidneys weighed 10 ounces, and very little cortex was left, being replaced by cysts from the size of a pea to that of a marble, some containing a clear fluid, others dark brown colloid-looking matter; some observers have found urea in the contained fluid, others have failed to do so.

Various descriptions of their origin are given. Some say that the microscopic cysts are dilated flexures of the convoluted tubes, whose communications are hard of discovery; others, that parts of the convoluted tubes, having lost their epithelium, are cut off by inflammatory changes, and become distended; perhaps, as Johnson suggests, by a watery secretion from the uninucleated cells before mentioned.

Some cysts are lined by pavement epithelium, which suggests their possible formation from the Malpighian capsules; congenital cysts are said to start almost always from the Malpighian bodies. Mr. Simon some years ago advocated the view that they arose from extravasated and overgrowing or dropsical renal epithelial cells.

Recognising an Interstitial Nephritis, it is conceivable that the new tissue in contracting acts unequally on the tubules, causing dilitation in one part and atrophy in another.

Rindfleisch describes minute cysts in the medullary substance, sometimes so numerous as to form beaded rows; he regards them as due to cystoid degeneration of the looped tubes of Henle, ushered in by the colloid metamorphosis of impacted cylinders of fibrin. The cysts of the cortex he looks upon as mainly the result of strangulation of the convoluted tubules; but for the origin of some he accepts the following interesting explanation by Virchow:—"The first rudiment of a cyst is composed of a round circumscribed spot about the size of a hempseed, in the region of the convoluted tubes; within this area all the tubes are markedly dilated, and their walls furred together, so that in the aggregate they present the appearanee of a single cyst traversed by thin septa. These septa next undergo atrophy, where they are thinnest. The dilated tubes communicate with one another, and finally coalesce to form a single cyst of larger dimensions. The remains of the septa shrink back like a torn cobweb upon the walls of the cyst, where they may be found, even in cysts of considerable size." It is certainly hard to believe that the large cysts can be each the offspring of a single microscopic tube, and in itself Virchow's explanation is a plausible one.

Another possible occurrence is the coalition of microscopic cysts in process of growth, and absorption of the partitions. These structures, so peculiar to a granular kidney, are of great interest, and merit longer consideration than our time will admit of. I should mention that some writers describe particularly a vicarious development of the tubes of the medullary portion of the organ; here and there may be seen elaborate tufts and convolutions, and the canals are dilated.

This seems the best place in which to quote some interesting statements made by Professor Charcot in a recent lecture, an abstract of which is given in the *London Medical Record* for March 15th. He finds that there is one epithelial change common to all visceral cirrhoses, of the lung, liver, and kidney. His words as regards the last are these:—

"Histologically there are two prominent facts: (1) The epithelium of the convoluted tubes undergoes granular degeneration and finally disappears; (2) The connective tissue which surrounds and sustains the tubes undergo embryonic transformation, and is developed in excess. But I request your attention on one point: At a given moment the dark granular epithelium, which in the normal state lines the convoluted tubes, is replaced by cuboid epithelium, resembling that of the collecting tubules. It seems to be a fundamental characteristic of the small red kidney, and if met with in other forms, is so only accidentally and in places." He then attempts to show, by a short description of the development of the organs, that the changes are fundamentally "reversion to the embryonic state of the parts developed from mesoblast, and so far as concerns their epithelial lining, a tendency to reproduce the characters of the fœtal state.

(To be continued.)

UNITED HOSPITAL ATHLETIC SPORTS.

On Saturday, June 29th, the above sports were held at the Lillie Bridge Grounds. The event was favoured not only with a fine day, but with numbers of spectators, the brilliant colours of the fair sex being conspicuous. The successful competitors for Guys were—L. Stokes, two events (¼ mile and 250 yards); T. Shepherd, two events (long and high jump); J. A. Fraser (putting the weight), E. Fasken (consolation race), so that Guys' scored five First Prizes and the Consolation Race. The next to us were St. George's, two First Prizes and four Second; Guy's, therefore, obtained the *Shield* with comparative ease; this makes the fifth time we have obtained it. A full account will be given in our next number.

CHLOROTIC CLARA, M.D.;
OR,
THE PATHOLOGICAL PAPA AND THE ANÆMIC ALFRED,
A MEDICAL ROMANCE.

CHAPTER II.
"THE SOCIETY FOR THE TOTAL SUPPRESSION AND ABSOLUTE PROHIBITION OF SAUSAGE MAKING."

(*Continued from page* 71.)

But Clara had no time for such trifling; she was now engaged in a far more interesting pursuit. She had been appointed Secretary to the above-mentioned society.

A report had reached her ears that every sausage-maker in the kingdom habitually made use of live cats in the conduct of his business, as her informant stated, on account of the superiority of flavour supposed thereby to be acquired by the sausages. A meeting was immediately summoned, Clara voted to the chair, a subscription list opened, and pamphlets denouncing the sausage-makers and their business freely distributed.

Picturesof a cat being distended with Cayenne pepper through a tube, and afterwards finely minced alive in a sausage machine, were placarded about the streets, and finally public opinion was stimulated to such a pitch that a Parliamentary investigation took place. Two months were occupied in close inquiry, 300 witnesses examined, and 15,224 questions were put and answered.

The opponents of sausage-making were interrogated, and stated that "they believed live cats were used in the manufacture of sausages; they supposed that Cayenne pepper was administered, and cats were minced up while in a living state; they imagined that mustard was most probably put into cat's eyes for the pleasure it must afford the sausage-makers in witnessing their sufferings."

Cat's eyes had certainly been seen placed in pure alcohol.

One of the witnesses had heard shrieks and yells every evening proceeding from a well-known sausage-maker's premises, and had seen a tabby cat's skin hanging on the wall of the premises.

Questioned further, it transpired that none of the witnesses had ever seen a sausage machine at work, or had any acquaintance with any of the leaders in the trade.

Asked if they hunted, shot, or fished for pleasure, they unanimously replied in the affirmative. Questioned as to what they considered the amount of enjoyment the stag and fox derive from being hunted to death, the birds from being unskilfully lamed and left to die of gangrene, the fish from the hook in its entrails, they replied that they didn't know and didn't care, in fact, they had never thought about it at all.

The witnesses on the other side were now examined. The eminent Mr. Squiff, who had a large establishment at Florence Villas, and whose evidence was corroborated in every particular by Messrs. Burdenson and Pine, stated, "That live cats were not employed in sausage making, either by himself or any any other manufacturer."

There was a fatal disease which afflicted alike animals and human beings. The only way in which the origin of this disease could be discovered and a scientific treatment applied was by examining under anæsthetics a certain number of living animals.

Cats were chosen on account of a wide-spread and occasionally justifiable belief that the flesh of these animals entered rather largely into the composition of the common household sausage.

The reason for this was that in former years, before dissections were made, many persons had died, and animals also, from eating sausages made from diseased meat. In the interests of humanity he should still continue to sacrifice a small number of cats. If prevented from doing so, he should take his departure for a more enlightened sphere, and give other countries the benefit of his advice and discoveries. He believed, however, that the present commotion was promoted by a very small number of persons whose cerebral convolutions would probably be found extremely badly developed. The shrieks and yells heard proceeding from his premises were caused by his eldest son, who was learning to play the violin.

Mr. Squiff's opinions were supported by other sausage-makers, with the exception of two or three aged manufacturers, who stated, "That they were not particularly well acquainted with the processes used for detecting diseases in cats. They had experimented occasionally themselves, but had never discovered anything, and so considered that experimentation was useless."

At length, however, a law was passed that the manufacture should only be carried on in licensed houses, and under the eyes of two policemen.

This did not satisfy the requirements of the Abolitionists, and they subsided at last into a chronic state of penny pamphleteering, and, perhaps, dear Reader, they still continue so, for all this happened a long while ago, when we were very, very much in want of School Boards.

STRICTURE OF RECTUM—COLOTOMY—RECOVERY.

UNDER THE CARE OF MR. BRYANT.

C. H., æt. 28, married; No. 10, Lydia Ward; mother died of cancer, family history otherwise good. Patient was healthy up to time of marriage, five years ago, six months after which she miscarried, and since then she has neither menstruated nor been quite well. Two and a half years ago patient felt a strange itching about lower part of rectum, with pain in defæcation, which was soon followed by discharge of blood and matter per anum.

Sixteen months ago she commenced passing very small motions, and was treated, as an in-patient at the Soho Hospital, by bougies, but she did not derive any permanent benefit from it.

For the last six months she had not passed any solid motion, and during the last week the bowels have not acted at all, but there has been a constant discharge of blood and matter, with straining and pain.

On admission into Lydia Ward, 7th May, 1878: patient is a small, sickly-looking woman, complaining of severe pain over abdomen, and of constant discharge from anus. Abdomen is distended; coils of

intestines can be traced through the parietes. About an inch and a half from anus there is a long tight stricture of the rectum, which would just admit a No. 10 catheter; the bowel from the stricture to the anus being one mass of ulceration.

On May 10th, at 2 p.m., Mr. Bryant made an oblique incision, about three and a half inches in length, in the left lumbar region, cut down on the colon, passed three silk sutures through it, opened it between them, and attached it to the parieties. A triangular stitch was used in addition at either end of the opening and the wound dressed wtth dry lint.

8 p.m. —T., 104°; P., 130; ℞ Morph. Hydrochl. gr. ¼, sub. cute.

May 11th.—M. T., 103°; P., 120.

May 11th.—E. T., 102°; P., 120.

Motion already passing through the wound, which looks healthy; some vomiting.

May 12th.—M. T., 99·4°; P., 100. Diffused pain over abdomen, which is tender and slightly distended; vomiting continues.

May 13th.—M. T., 98; P., 96; much better; vomiting ceased.

May 18th.—Sutures removed; the bowel has everywhere united to the parietes; healthy motion passes through opening in intestine.

June 16th.—Patient is leaving the hospital to-day; she has no pain in defæcation, the wound has entirely healed, and the intestine protudes about a quarter of an inch, forming a perfect anus.

CASE OF UMBILICAL HERNIA.

H. B., æt. 5 days, admitted into Martha Ward, May 3rd, 1878, with vomiting but no constipation.

On examination, a tumour was found extending from the abdominal cavity into the umbilical cord, as far as the ligature, which was intact, being of about the size of a small orange and of a dirty reddish black spotted color, very moist and at the usual point of separation of the cord from the abdominal walls (the skin of which was protruded one inch over the cord) was an inflamed ring marking the point of separation. When the child cried a distinct impulse could be felt. The tumour was firm in consistence. Being moist, Pulv. Zinci. was applied.

By the 8th the sloughing surface had come away, leaving a freely granulating surface 2 inches by 1, now dressed with Ung. Zinci. Child fed with diluted milk from bottle from now till the 20th, the tumour gradually contracted down, but some vomiting and constipation occurred, for which, Pulv. Rhei. et sodæ, gr. iv. ordered, which caused relief.

May 28th.—The swelling had so diminished that one was able to reduce it "en masse" into the abdominal cavity. A graduated compress of dry lint was applied and strapped on with the hope of setting up some adhesion between the abdominal walls and the granulating surface.

June 1st.—Child vomiting, blotches on thigh (right) and buttock of same side, with loss of flesh and old appearance, Hydrarg. c. Creta. gr. j. ordered, omni nocte maneque.

June 4th.—Compress removed, the tumour not returning, and again reapplied.

June 10th.—Compress removed, very good adhesion had taken place, leaving a cruciform umbilicus, but child rapidly failing, looking very old, and losing flesh, and sinking.

June 12th.—Child died.

P.M.—On opening the abdomen. A portion of the liver, Lobus Quadratus, and gall bladder were attached to the liver only by a small isthmus, the bile duct being pervious; this pear shaped mass was attached by its fundus to the umbilicus by thin fibrous tissue. Over the peritoneum covering it was a dark circular ring which might have been the granulating surface, and it was evident that this lobe was the hernia. Cause of death specific inanition.

The specimen is now in the Pathological Museum.

F. B. J. BALDWIN.

SEPARATION OF LOWER EPIPHYSIS OF HUMERUS—OCCLUSION OF BRACHIAL ARTERY.

S. M., æt. 5, No. 26 Cot, Lydia Ward, a healthy-looking boy. On May 15th fell dowu some stairs, striking his right elbow. He was at once brought to the surgery. On examination the lower epiphyses of the humerus were found to be separated from the shaft, and to be displaced backwards with the fore-arm; also the brachial artery was found to be obliterated at the point of fracture. A rectangular anterior splint was put on, and the child sent away. Whcn again seen on May 22nd the elbow was very swollen, so he was admitted into rhe hospital. On admission the elbow was very much enlarged, the skin discoloured, and two large bullæ had formcd on the front of the joint; the arm was flexed at a right angle, and every movement gave great pain. Pulsation was absent in all the vessels below the line of fracture, but the hand seemed in its normal condition. The arm was laid on an inside splint and ice applicd.

June 2nd.—Pulsation returned in lower part of brachial artery, and there is a slight pulsation in radial.

Jnne 16th.—On leaving the hospital the pulsation in tne right radial is considerably less than that in the left, the arm can be flexed to a little less than that of a right angle, and also partly extended. The movements of pronation and supination are complete.

[We have to thank Mr. Charles Wood for the above.]

STATISTICAL REPORT OF GUY'S LYING-IN CHARITY FOR MAY, 1878.

Number of women attended				190
No death.				
Of these there were in their	1st	confinement	25	
" "	2nd	"	29	
" "	3rd	"	25	
" "	4th	"	26	
" "	5th	"	18	
" "	6th	"	22	
" "	7th	"	12	
" "	8th	"	13	
" "	9th	"	10	
" "	10th	"	4	
" "	11th	"	1	
" "	12th	"	3	
" "	13th	"	2	
				—190
Number of children born				193
Single births			187	
Twin births			3	
Number of full time children				189
Males alive			93	
Females "			93	
Males dead			2	
Females "			1	
				—189
Number of premature children				4
Females alive			1	
Females dead			1	
Males dead			1	
Sex doubtful			1	
				—4
Presentations :—				
Vertex			187	
Breech			2	
Vertex and hand			1	
Brow			1	
Vertex and funis			1	
				—192
Externs attended :—				
Mr. J. W. Saunders			43	
Mr. C. Crossley			30	
Mr. R. H. J. Scott			39	
Mr. A. D. Deane			37	
Mr. C. J. Harper			44	
				—193

No cases requiring instrumental or manual delivery occurred.

JOHN W. MEEK, L.R.C.P. (Lond.),
Junior in Charity for May, 1878.

APPOINTMENTS.

[By inadvertance the following was omitted in the *Gazette* of June.]

The following appointments were made on May 27th :—

Resident Obstetrics—Mr. Davy (June); Mr. Hammersley (July); Mr. L. M. B. Jones (August).

Dressers—Mr. A. E. Maylard (Mr. Cooper Foster); Mr. R. W. White (Mr. Bryant); Mr. J. H. Barnard, Mr. G. H. West-Jones (Mr. Durham); Mr. F. W. Fuller, Mr. E. Penny (Mr. Howse).

Dressers in Eye Wards—Mr. C. W. Lacey, Mr. E. H. Paddison, Mr. E. J. Morley.

Medical Clinical Clerks—M. F. B. Rayer, Mr. C. Crossley, Mr. R. E. Morse, Mr. T. G. Barns, Mr. A. H. Burton, Mr. C. J. Harper, Mr. Sanders, Mr. Fielding, Mr. C. Sage, Mr. P. S. Williams, Mr. G. Williams, Mr. E. M. Davies, Mr. A. H. Pierson, Mr. W. Whitworth, Mr. H. E. Wright, Mr. W. W. Wordley, Mr. Bedford.

Assistant-Surgeons' Dressers—(Mr. D. C.) Mr. J. G. S. Lewis, Mr. W. P. Morgan, Mr. T. H. Morse, Mr. F. S. Pilkington; (Mr. L.) Mr. W. P. Bothamley, Mr. E. O. Jago, Mr. F. S. Smith, Mr. H. H. Sturge; (Mr. G. B.) Mr. T. T. Brett, Mr. J. S. Crook, Mr. S. T. Thomas, Mr. L. C. Woolridge; (Mr. J.) Mr. E. H. Davies, Mr. H. A. Philips, Mr. S. H. Moore, Ms. O. R, Shelswell.

Assistant Physicians' Clerks—(Dr. F.) Mr. H. E. B. Flanagan, Mr. R. J. H. Scott; (Dr. Pye-Smith) Mr. Howell, Mr. E. Fielding; (Dr. T.) Mr. A. Scott, Mr. H. H. White; (Dr. G.) Mr. C. A. Haycroft, Mr. N. E. Johnson-Gaylor.

Obstetric Out-patient Clerks—Mr. G. F. Symons, Mr. W. T. Crew, Mr. J. T. J. Morrison, Mr. E. O. Stuart, Mr. P. S. Williams, Mr. G. Williams, Mr. P. M. Wood.

Dental Surgeon's Dressers—Mr. N. E. Johnson-Gaylor, Mr. E. A. Starling, Mr. H. R. Osborne, Mr. F. N. Pedley.

Aural Surgeon's Dresser—Mr. F. F. Jones.

Post-mortem Clerks—Mr. W. J. Parkinson, Mr. A. Langridge, Mr. H. H. Sturge, Mr. J. W. Sanders.

Dressers in Surgery—Mr. W. Gruggin, Mr. A. P. Hills. Mr. A. C. Otway, Mr. F. M. Godde-Smith, Mr. J. F. Tabb, Mr. J. T. Boswell, Mr. H. G. Ashwell, Mr. T. R. Atkinson, Mr. W. W. David, Mr. J. M. Owen, Mr. L. W. K. Philips, Mr. D. D. Pryor, Mr. G. R. Rolston, Mr. E. A. Starling, Mr. B. S. Studen, Mr. J. T. Udale, Mr. E. R. D. Fashen, Mr. L. Burroughs.

Surgical Ward Clerks—Mr. W. Gruggin, Mr. H. E. Archer. Mr. H. E. Ashwell, Mr. T. W. L. Beales, Mr. H. W. Campbell, Mr. W. H. Crowe, Mr. W. W. David, Mr. G. M. Owen, Mr. L. W. K. Philips, Mr. N. W. Pryor, Mr. J. R. Roston, Mr. H. P. Rollands, Mr. G. W. Shaw, Mr. D. C. Trott, Mr. T. J. Udale, Mr. P. H. Gardiner, Mr. Prendergast, Mr. J. Rigby,

Assistant-Surgeons' Clerks—Mr. T. R. Atkinson, Mr. Mahomed (Monday); Mr. G. F. P. Pizey, Mr. B. Lane (Wednesday); Mr. D. C. Grott, Mr. W. H. Grosse (Thmrsday); Mr. T. W. B. South, Mr. E. S. Adeney (Saturday).

Extern Obstetric Attendauts—Mr. Peskett, Mr. Maylard, Mr. Brocklin, Mr. Fuller, Mr. Penny (June); Mr. Howell, Mr. Stuart, Mr. Clowes, Mr. Perkins (July); Mr. W. H. White (August).

Dressers for the week ending—

June 4th	Mr. E. Roper.
" 11th	Mr. G. Pilkington.
" 18th	Mr. Wells.
" 25th	Mr. G. H. Russell.

The following appointments have been made by the Treasurer for the ensuing months :—

House Physicians—Mr. E. C. Beale, Mr. G. A. Wright, and Mr. J. C. Uhthoff.

House Surgeons—Mr. J. Hammersley, Mr. C. Knox Shaw, and Mr. R. S. Wainewright.

ON DUTY FOR JULY.

Senior House Physicians—Mr. C. Knox Shaw and Mr. A. G. Barrs.

Junior House Physician—Mr. E. C. Beale.

Senior House Surgeons—Mr. G. A. Wright and Mr. T. R. Judson.

Junior House Surgeon—Mr. J. Hammersley,

Resident Obstetrics—Mr. H. Davy and Mr. L. M. B. Jones.

DRESSERS FOR THE WEEK.

July 2nd.—Mr. Crooke (Mr. Howse).
" 9th.—Mr. Deare (Mr. Foster).
" 16th.—Mr. White (Mr. Bryant).
" 23rd.—Mr. Baldwin (Mr. Durham).

THE following appointments in the Medical School are vacant:—

Surgical Registrar.
Two Assistant Demonstrators.

Applications should be forwarded to the Treasurer not later than Tuesday, the 9th July.

Mr. H. DAVY was appointed House Surgeon by the Treasurer, but owing to other work was unfortunately obliged to resign the appointment.

GUY'S HOSPITAL PUPILS' PHYSICAL SOCIETY.

SESSION 1878-9.

During the Session 1878-9 Dr. Wilks has kindly consented to remain Honorary President of the Society.

The following presidents have been elected:—Messrs. H. Davy, W. D. Hartley, P. Horrocks, M.B., W. Lane, G. Mackern, A. E. Maylard, J. T. J. Morrison, J. Poland, B. N. Rake, G. H. Russell, A. Scott, C. T. K. Skaw, T. S. Sheldon, J. C. Uhthoff, R. S. Wainewright, W. H. White, L. C. Wooldridge, B.Sc., and G. A. Wright, B.A., M.B., F.R.C.S.

Messrs. Clement Lucas and C. J. Symonds remain Honorary Secretaries, and act as Treasurers of the Society.

Two Prizes of the value of £10 and £5, in Books or Instruments, will be awarded for the best Papers read before the Society during the Session.

A Prize of the value of £5 will be given for the best Essay on the following subject:—"The Pathology and Treatment of Chronic Joint Disease."

The Essay must be illustrated by cases which have been in the Hospital during the Candidate's Studentship.

A Prize of the value of £5 will be given for the best Essay on the following subject:—"The Physiology and Histology of the Lymphatic System."

A Prize of the value of £5 will also be given to the Member who has distinguished himself the most in the debates during the Session.

N.B.—The Judges have the power of dividing the Prizes should two of the Candidates possess equal merit, or of withholding them, should insufficient merit be displayed.

CONDITIONS.

1. Candidates must be Members, neither holding nor having held any office in the Society.
2. No Member who is legally qualified to practise his profession is eligible as a Candidate.
3. Two Prizes may not be awarded to the same Candidate.

THE FOLLOWING REFERS ONLY TO THE ESSAY PRIZES.

4. Each Essay must be distinguished by a motto or device, and accompanied by a sealed note, inscribed with the motto or device, and containing the author's name.
5. The Essays are to be delivered at the Library, under cover, to the Honorary Secretaries, on or before the 1st of March, 1879, in order that they may be examined by a Committee of the Presidenis for adjudication.
6. The Essays of the unsuccessful Candidates will be returned on application at the Library, with the notes that accompany them unopened.

The Prizes were awarded at the end of last Session as follows:—

To Mr. G. H. Russell, £10, for his Paper on "Intestinal Obstruction."

To Mr. J. Poland, £5, for his Paper on "Secondary Hæmorrhage and the Application of Torsion."

To Mr. J. T. J. Morrison, £5, for his Essay on "The Pathology of Chorea."

To Mr. B. N. Rake, £5, for his Essay on "The Localisation of the Functions of the Brain."

To Mr. W. H. White, £5, as the Member who had distinguished himself the most in the debates of the Session.

We heartily congratulate the prizemen mentioned above on their success, and specially those who have obtained prizes for their respeetive essays on "The Pathology of Chorea," and on "The Localisation of the Functions of the Brain." In certain years no essay has been sent in, and consequently the prize has not been awarded. We would, therefore, specially call the attention of our readers to the two prizes mentioned above to be given in 1879, one for the best essay on "The Pathology aud Treatment of Chronic Joint Disease," the other for the best essay on "The Physiology and Histology of the Lymphatic System."

We would also remind those who intend reading papers during the next Session to give their names to one of the Presidents as soon as can be managed.

NOTES OF THE MONTH.

ROYAL COLLEGE OF SURGEONS (England).—The following gentlemen having passed the final examination for the Fellowship, were duly admitted Fellows of the College on June 13th:—Mr. F. T. Paul, L.R.C.P.; Mr. G. A. Wright, M.B., Oxon.

UNIVERSITY OF EDINBURGH.—The following gentlemen have passed the final examination for the degrees of M.B. and C.M. at this University:—Mr. J. M. Hobson, Mr. J. F. T. Sykes, and Mr. T. Richards.

NEWS has been received that our energetic fellow-students who offered themselves as Surgeons in the Kaffir war have safely reached their destination. We hope in some future number to record their exploits.

N.B.—IN future all communications respecting advertisements and business matters of the *Gazette* are to be sent to A. SCOTT, Esq., Guy's Hospital.

ANTISEPTIC GAUZE, BORIC LINT, PURE CHLOROFORM,
and other preparations recommended by Professor LISTER, ANHYDROUS ETHER
for producing Anæsthesia, as used by Dr. THOMAS KEITH.
PREPARED BY
J. F. MACFARLAN & Co.,
Manufacturing Chemists, Edinburgh, & 5, Barge Yard, Bucklersbury, London.

GUY'S HOSPITAL GAZETTE,
AUGUST, 1878.

CASE OF ENTERITIS AND TUBERCULAR PERITONITIS.

WITH REMARKS BY DR. GOODHART.

A man, aged 45, was admitted on June 5th, 1878. He was in a state of extreme collapse with hardly perceptible pulse, considerable lividity of face and extremities, and profuse cold sweat. He was quite sensible, but groaning with abdominal pain, the legs being drawn up towards the abdomen. The abdomen was rigid, but not distended, and the abdominal pain was not increased by palpation. The pain was most intense in the Epigastric region. Rectal examination revealed nothing. He stated that he was a Wharf labourer, carrying sacks of corn on his back, and that he had strained himself at work a day or two before his illness began. However this might be, he felt no ill effects for three days, when he was taken with slight abdominal pains lasting a quarter of an hour or so. His companions noticed also on that day that there was something the matter, as he would not go and drink with them as usual. The next day the pain recurred, and again on the following day, and on the same evening. The day before his admission he was seized with intense abdominal pain.

He had had no previous diarrhœa. The bowels had acted regularly daily, except the day before his admission. He then took two pills, which acted slightly the morning of his admission; the evacuation being of dark colour. His last meal was two days before his admission. Since his last severe seizure he had vomited everything.

Well, there he lay evidently desperately ill, and we could obtain no more information. The milk that was given him was vomited instantly, so we confined our treatment to opium. He had a grain of opium on admission, which was ordered to be repeated every four hours, and the opium failing the first time he had in addition a third of a grain of acetate of morphia injected subcutaneously. But he never rallied and he died the same evening.

The diagnosis which seemed probable under the circumstances was acute peritonitis, and that coming on suddenly in a previously healthy man is mostly due to perforation of some part of the alimentary tract, either from gastric ulcer,—which, as I told you at my last lecture, produces sometimes no definite symptoms—or from perforation of the appendix cæci, occasionally from some typhoid ulcer in the ileum, the typhoid fever having remained apparently latent; occasionly from some ulcer in the colon.

But there were some other possible issues raised, and chiefly these: Had the man taken some poison? or had some form of blood poisoning wrought the mischief? With regard to the first of these, it was not till after death that this possibility suggested itself, because there was no suspicion of any other than the straightforward tale told on the man's admission, and moreover the symptoms wanted one very important symptom of irritant poisoning, viz., the purging.

Blood poisoning may not seem to you at first sight at all likely with such symptoms as the man showed, but I must remind you that if the product of putrid inflammations be injected into dogs' veins, in sufficient quantity, they will die off in a very few hours, cold and collapsed, vomiting, and often purging, as in the cold stage of cholera in man. Moreover, too, if any of you who saw this man have seen any cases of malignant or petechial scarlatina or small pox, you will have been struck with the close resemblance of the cases in many important points. I remember very well some years ago being called out into the country to see a child who was said to be very ill. It was a Sunday night, and the father told me that to all appearances she was quite well in the afternoon and went to church, where she was sick. With that history, and knowing that there was scarlatina in the neighbourhood, I ventured to leave the case for some two hours, while I finished some other work nearer home. When I got to the house at about 10 p.m. the child was moribund, cold, collapsed, insensible, and with a copius petechial rash all over it; and it died within a short time. The duration of the whole attack was not twelve hours. I remember seeing a somewhat allied case of small pox in Snowsfields ten years ago, where the patient died in a very short time, and where, except for the petechial rash, the symptoms might very well have been put for those in this patient. So that blood poisons destroy life occasionally very rapidly, and the collapse in such cases is very remarkable. There is, however, usually a comatose state in such, while the mind remains clear in the cases of peritonitis.

I don't think I can say much more about the differential diagnosis of these various conditions, because they are all so similar, and you will have to decide, as far as possible, by the history and surroundings of the patient, his manner, habits, tendencies, &c., a number of little things upon which it is impossible to dilate beforehand.

With regard to some perforating ulcer of the stomach or intestine (which this case implied), however, I may say this much to put you on your guard, that they have frequently been the subjects of Coroners' inquests, having raised suspicion of foul play. Only the other day I was asked to make a post-mortem for the Coroner upon a woman who had been under treatment for some trivial ailment, but who died so suddenly that her friends thought the doctor must have poisoned her. The post-mortem was made by Mr. Lacey, and a perforating ulcer of the stomach was found. A series

of similar cases has quite recently been published in one of the medical journals, by Dr. Dunlop, of Glasgow.

"At a recent meeting of the Clinical and Pathological Society, the writer showed five specimens of perforating gastric ulcer of the stomach, and one specimen of perforating ulcer of the decending colon, which he had found in the course of the medico-legal practice of the city.

"In all the cases there had been sudden and unexpected death, and regarding some of them, there was not only much attention excited, but there was a strong suspicion that death had not been produced by natural causes, but that poison had been administered with the intention of taking away life.

"The first specimen shown was removed from a healthy looking young woman, aged 21 years. She was of the Roman Catholic religion, and in addition to being held in good repute in the church where she worshipped, she appeared to have been much respected by the people resident in her neighbourhood. The girl was to have been married to a man to whom she had been engaged for a short time, and the ceremony was to have been performed in the chapel on a Sabbath day. On the Saturday night preceding there were a number of friends present in the house of the young woman's mother, and the entertainment was described as innocent and simple. One of the party present was a young man, with whom the young woman had formerly been on friendly terms, and it was rumoured that she ought to have married him.

"About 11 p.m. the mother was informed that her daughter was going to accompany some of her friends a little way down the road, and specially that she meant to say good-bye to the young man above referred to. They all went out together, and within an hour thereafter she returned home alone.

"On her return she partook of a hearty supper, consisting of bread, tea and mince-meat, and shortly thereafter went to bed. About an hour afterwards, while lying quietly in bed, she complained to her mother of her stomach being very much swollen and painful. While she was screaming with the pain and with sensations as if her abdomen was going to burst, she felt something tearing in her inside, and this was at once followed by a feeling of heat which pervaded the entire abdominal cavity, aud by a sense of relief from the painful distension of the stomach. Soon, however, the pains returned, not only in the stomach but all over the abdomen, and they continued all night and all morning. By three o'clock on the afternoon of the Sabbath day upon which she was to have been married, she died in great agony.

"Immediately before death the girl was asked if she had taken anything while out with the young man, or if she had partaken of anything before going out with him, or if she connected her illness in any way with his visit or her approaching marriage. These questions she answered in the negative. Her death was so sudden and so untimely, and from the fact of a discarded lover having been the last person who had been seen with her out of her own house, suspicion of foul play was suggested, and it was more than hinted that he must have given something which killed the girl. Till the *post-mortem* examination was made by the directions of the Crown, the individual suspected was kept under a kind of supervision. At the inspection death was seen to have been due to perforation of the wall of the stomach, and to general peritonitis which had been set up.

"Lying among the intestines was found a considerable quantity of food, which had streamed into the abdominal cavity through two ulcers or openings in the stomach.

"On making a careful inquiry into the history of the case it was learned that the girl had always been healthy, that she had not been absent from work for a single day in consequence of illness, but the mother stated that during the two or three months that preceded her daughter's death, she had on several occasions spoken of having had crampy pains in the stomach, especially after taking vegetable soup, but except on these occasions she had not been known ever to complain.

"The specimen was very interesting, and was an example of what is not often found, namely, a double perforating ulcer. There was a very typical ulcer on the posterior surface of the stomach, about $2\frac{1}{2}$ inches from the lesser curvature, and on the anterior surface there was another. The two ulcerated surfaces having been in exact apposition, they were both of the same size. The peritoneal or external surface was about the size of a sixpenny-piece; the mucous or internal was larger than a shilling, though not quite so large as a florin. Their edges, however, were not the same. Around the posterior ulcer for a distance of nearly half an inch the mucous membrane was swollen and indurated, while the edges of the anterior ulcer, though also swollen and raised above the level of the surrounding mucous tissue, were much thinner, and presented altogether the appearance of having had a lesser degree of inflammatory action in them. The evidence afforded by the margins of these ulcers suggested the view of the posterior ulcer having been first formed, and, as Brinton pointed out, may have caused the anterior one by simple but perpetual contact. Both, however, so far as could be judged from the indurated edges of the ulcer, seemed not to have been recent in their formation but may have had an existence for a considerable period—possibly weeks or months."

(To be continued.)

THE following Guy's men were successful at the recent Preliminary Scientific Examination:—First Division, Brogden, Champ, Dashwood, Hart, Lever, Price, W. E. Starling, Stedman, Sutton, E. Roberts. Second Divison, Cuff, Davies, P. J. Jackson.

FROST BITE.
GANGRENE, DOUBLE AMPUTATION.

Mr. Bryant has kindly permitted the following report to be published—

T. B., æt. 28, sailor. Admitted, 1st April, 1878; Job Ward.

General health good; does not as a rule feel the cold much.

Left England last January for Norway in an ice ship, and arrived there in February after a long and cold voyage. He there first began to feel a numbness about the feet but not in the hands.

Remained in Norway a fortnight and during the whole way back to England the numbness continued.

Arrived in England 9 days ago, and says he was working for the first 5 days after his arrival in unloading the ship. He then got into a barge alongside and remained in the cabin of it 4 days without food.

During this time the numbness of the feet increased, and on the 1st of April, the river police brought him to this hospital in a comatose state.

On admission.—Both feet were cold, white and wax like and a vascular line was seen a little above the ankle-joints with some skin torn slightly from it. Mr. Russell tried to restore circulation in the feet by friction with iced water for about an hour. They became warmer and he thought the circulation was re-established, and then wrapped them up in cotton wool. In the afternoon they were again in the same cold waxy condition, and they were then wrapped in oiled lint and cotton wool.

No pulse at first. The face was covered with blue patches on the nose and cheek. Patient could feel when touched on the feet.

April 2nd.—Appears very sleepy and unwilling to answer questions. The feet are redder in colour and warmer than yesterday.

April 3rd.—Temperature, 100°. Feet cold again.

April 4th.—The feet have turned quite dark-coloured with a greenish blue tint, getting whiter between the instep and the former line of demarcation, which now is very red and distinct, the parts below being obviously in a gangrenous condition.

April 5th.—Temperature, 101·2°. Appears drowsy still. No sensation in the feet. CHCl 3 administered, and both legs amputated; left leg about the middle, right leg a little lower down. Bleeding vessels twisted. A flap of periosteum left on each bone, and the wound brought together by 2 flaps of skin with stitches, a horse hair drain being left in.

April 6th.—Temperature, 101·6°; Pulse, 108, weak and irregular. Slept well.

April 8th.—Wounds going on well, appears to have had no control over his bowels or urine since his admission. Temperature, 100°; Pulse, 90.

April 12th.—Eruption of vesicles containing colourless fluid, over the chest. Quin. Sulph. qr. V. Acid Sulph. dil. ♏ jjj. Aquæ ℥ j. 6th horis.

April 15th.—Pulse full and compressible, tongue dry.

April 17th.—Still appears to have no control over his bowels. Skin dry. On right leg the flaps loosened on the upper half, so as to expose the bone, from the end of which a lump of spongy granulations projects.

The wound in the left leg united by primary union, but broke through again in the middle part. Pulse, 98; Temperature, 100°.

April 24th.—The right leg looks healthy with granulations on upper part. Left leg discharging slightly.

May 10th.—The left leg has healed. Right leg is granulating. Temperature, 102·8°; Pulse, 104.

May 23rd.—Progressing favourably; Pulse, 84; Temperature, 98°.

May 28th.—There is an open surface of the size of a shilling at the end of right leg.

June 3rd.—Progressing favourably.

[We have to thank Mr. W. E. Rudd for the above.]

CASE OF MALIGNANT PUSTULE,
UNDER CARE OF MR. COOPER FORSTER.

Alfred Pope, æt. 17.

Occupation, *Tanner*.

Was admitted June 18th, 1878.

Family history.—Good.

Previous history.—Had an abscess on thigh two years ago, which came without any apparent cause, and disappeared without giving much trouble.

On the morning of June 13th he noticed a small red pimple on his forearm, which, he says, did not come to a point or discharge any matter, and for the appearance of which he is unable to account.

He continued his work as usual, but on the morning of Sunday, June 16th, the arm became very painful, red, and much swollen—the pain extending all along the arm to axilla, in which the glands were enlarged and tender.

Applied a linseed meal poultice, and on removing it he noticed that the pimple had disappeared, and in its place was a small round black spot. Poulticing afforded but little relief, the arm becoming gradually more inflamed and swollen.

On Monday he was unable to go to work, feeling sick and weak.

Slept badly on Monday night, and on Tuesday morning applied to Guy's, when the nature of the case being at once diagnosed he was admitted into Cornelius Ward.

On admission—.Temperature, 101·2°.

Rather above the middle of left forearm anteriorly

there is a small oval sore about ½ inch by ¼ inch, the centre of which is depressed and distinctly black. Outside this is a narrow ring of a yellowish colour, and outside this again there is an elevation of the skin forming the outer deep margin.

The whole arm and forearm is very red and painful to touch.

Glands in axilla enlarged and painful.

Three hours after admission Mr. Cooper Forster made an incision around the sore at a radius of one inch from centre, dissected off the skin as deep as facia, covering the muscles, and removed the pustule with it.

Dressed antiseptically.

June 19th.—Temperature, 97°; Pulse, 64.

June 20th.—Temperature, normal; Pulse, normal.

Wound was dressed at intervals, at first of a day, then of two days, and never suppurated. Granulations sprang up at edges of wound, gradually spreading to centre, and on July 2nd he was discharged from Hospital, there being a small granulating wound about ¼ of an inch in width.

He has been attending since to have his arm dressed in the Surgery, and it has almost entirely skinned over.

[We are indebted to Mr. A. G. Wells for the above report.]

CASE OF ENTERITIS AND TUBERCULAR PERITONITIS.

John W., aged 45, a wharf labourer, from Angel Court, Borough, admitted on Wednesday, June 5th, at 2.45 p.m., into Clinical Ward.

No history of any previous illness, or Diarrhœa.

He stated that he had strained himself whilst at work at the Wharf. On Sunday, June 2nd, three days before admission he was taken with slight abdominal pain which lasted about a quarter of an hour and then left him. This occurred again on the Monday and also on Tuesday. In the evening previous to admission (Tuesday) about 9 o'clock he was seized with intense abdominal pain which continued up to the time of his admission into the hospital. Everything that he attempted to take he almost immediately vomited up again. Bowels were open on the Sunday and Monday, but not on Tuesday, when he took two pills, bowels open on morning of admission, only a small quantity of fæces passed of a very dark colour. He ate his dinner on Sunday but since then has only attempted to take milk or water, he was able to keep a little of the milk down on Monday.

On Admission.—Patient a very healthy-looking muscular man, lying on his back in a collapsed condition. Face pale and blue, lips not blanched but livid. Extremities cold and livid. Pulse scarcely perceptible. Groaning with intense excruciating abdominal pain. Legs drawn up somewhat towards abdomen. Abdomen rigid, not distended, no excessive abdominal tenderness. The pain appeared to be most intense in the epigastric region. Mind quite clear, was able to answer questions that were put to him. No hernia. Nothing to be felt per rectum, no blood. Temperature 97°. Chest and Heart normal.

Turpentine stupes were applied to abdomen and ½ oz. of Brandy administered in water, this he almost immediately vomited up. Pil opi. gr. i. he was able to keep down; at 4. p.m. he had Hypodermic injection of Morphia gr. ⅓.

He became more and more collapsed and cold, with imperceptible pulse and cold sweating, the vomiting also continued until he died at 7.45 p.m.

No urine or fæces passed.

At Post-mortem.—No very distinct inflammation of peritoneum, but it was perhaps a little congested in parts. The mucous membrane of intestines presented a somewhat remarkable appearance. Throughout the small intestines and mostly at the lower part there were scattered several ulcers eight or ten in number, of small size but larger near the Ileum; they presented a sloughy greyish black surface on removing which the intestine was a little thinned.

The mucous membrane around these sloughy patches was œdematous and swollen, and intensily congested almost hæmorrhagic, of a very dark red nearly black colour.

Their peritoneal surface was also much congested.

There were two similar ulcers, but of very large size and irregular, in the large intestine; one in the splenic flexsure of colon, and they involved nearly the whole circumference of the bowel.

The mucous membrane between the patches appeared quite healthy.

Peyer's glands healthy. Stomach healthy.

Spleen soft.

Heart, Lungs and Kidneys were healthy.

[The above formed the subject of Dr. Goodhart's last Clinical lecture, on Wednesday, July 3rd, 1871.]

TREASURER'S MEDALS, 1878.

COMMENTARY ON A CASE IN MEDICINE.

John B., aged 39, a Blacksmith from Bedford, when 15 years of age, had ague, and this disease continued more or less for two years. He was then living in a village near Bedford. With the exception of this miasmatic fever, he had enjoyed good health; he had always been temperate in his habits, and had never suffered from any venereal disease. About 18 months before admission he began to fell languid and weak,—his complexion became sallow; still he took no notice of it till a year later, when he was seen by a medical man for an injury to the knee. The patient suffered from pain in the left side, and from palpitation of the heart. He was a thin, spare man, very anæmic in appearance, and sallow. The abdomen was considerably enlarged by a large tumour, which occupied the left hypochondriac region, and extended nearly to the crest of the ilium; it passed however

3½ inches to the right of the median line, and the lower margin was 2½ inches below the Umbilicus; a distinct notch could be felt on the right margin. The dulness on the left side extended upwards to the sixth rib, and backwards to the spine. The surface was smooth, but immediately below the ribs there was a projecting portion softer than the rest. There was bulging in the left lumbar region, and a rounded mass could be felt; this was however separable from the anterior tumour, and fluctuation could be indistinctly felt. The hepatic dulness extended from the seventh rib to a little below the margin of the ribs. The heart was pushed upwards, the cardiac dulness reaching as high as the second rib, and the apex beat was just above the nipple; the first sound of the heart was prolonged. The blood was examined microscopically, and found to contain a large excess of white corpuscles. The urine was of specific gravity of 1020, albuminous, and it contained mucus and phosphates. The patient passed a small calculus per urethram, about the size of a flattened pea, and it was found that the free passage of the urine was still interfered with; the flow was checked, and there was pain in the bladder. On December 9th, there was vomiting of bright green frothy mucus. On December 21st, the abdomen was larger, 37½ inches in circumference, and the enlargment in the loin was more promiuent. On December 24th, severe epistaxis came on and continued for 24 hours; it was then found necessary to plug the anterior and posterior nares. The plug was kept in about 24 hours, and was removed in consequence of fetid purulent discharge from the nostrils and from the right ear. There was some return of epistaxis on the 28th. The patient became greatly exhausted, deglutition was difficult, and he refused food. He gradually sank.

State the nature of the case, and give the pathological changes you would expect to find. What treatment would you adopt?

COMMENTARY ON A CASE IN SURGERY.

A boy, aged 13 years, was quite well nine weeks before he was first seen: he states he at that time had rheumatism in his left knee, and about two days afterwards in his right. The swelling extended in his left leg downwards to his foot, accompanied with intense pain. Four weeks after his first attack an opening appeared over the left shin, and matter came out. He has gradually wasted, but has not complained of pain anywhere except in his legs. His mother says he was always strong and hearty, and there is no history of rheumatism or gout in the family. Upon cross examination the boy remembers falling on his side and striking his left knee.

The present condition of the lad is as follows:—Both knee joints fixed; the right is devoid of swelling, but the skin over it is brown and desquamating, and the whole leg is dislocated backwards off the condyle of the femur. There is no fluid in the joint, the bony prominences being all well defined. The left leg is also dislocated backwards off the femur, and there is some evidence of fluid in the joint below the patella; the skin over the joint is red and thickened. Immediately to the inner side of the popliteal space behind the femur is a small opening discharging offensive pus; about the middle of the leg is another opening, and there are sloughs below the inner malleolus and on the dorsum of the foot. There is such extreme pain that no minute examination can be made.

Describe the nature of this case and the treatment you would adopt throughout; supposing extreme measures were resorted to, give the pathological appearances that would present themselves.

MR. G. A. Wright, M.B. (Oxon), F.R.C.S.E., has been appointed Surgical Registrar to the Hospital, Vice Mr. Frederic Durham resigned.

CHLORIDE OF ZINC.

Chloride of Zinc is a caustic which is employed in surgery for destroying morbid tissues; it is, however, very deliquescent and by no means convenient to use except it is previously mixed with some substance which tends to prevent this rapid liquefaction. A usual method when directly applied—as in bleeding cancer,—&c., is to sprinkle in plaster Paris as the caustic liquefies, and thus preventing it from coming into contact with the edges of the skin. Oxide of Zinc mixed with an equal weight of chloride will preserve the latter dry enough to blow through a tube into any cavity, and may be so kept in a bottle for some time. Such a preparation as this is employed by Mr. Higgins for opthalmic purposes.

I have prepared Chlorine of Zinc for Mr. Howse in a hard dry form by mixing together Zn. Clr. one part, Oxide of Zinc one part, Wheat Flour two parts, with water g.s. to make a stiff paste which is then rolled into cylinders and dried in an oven. One of the best forms of using this caustic is that of paste. The formula for Pâte de Canquoin is given in the French Codex as follows:—

Pr. Chlorure de Zinc	..	...	...	50
Farine de blé	...	...	...	50

F. dissoudre le sel dans g. s. d'eau dist: en triturant dans an mortier de porcelaine; ajoutez la farine et faites une pâte serrée quevous étendez en plaques. Conservez dans an flacon bouché. The paste thus prepared is extremly hygroscopic and it cannot be preserved for any length of time. If, however, Proof Spirit be substituted for the water, a much better result as regards keeping properties is obtained. H. COLLIER.

APPOINTMENTS.—July 23rd, 1878.

Obstetric Residents—H. O. Stuart (Aug.), F. H. Berry (Sept.) C. H. Keep (Oct.).

Clinical Assistants—Baldwin, Apthorpe, J. Osborne, Phillipps, Burton, Crooke.

Dressers—Malpas, Howell, Alexander, Briscoe, Bates, White.

Dressers in Eye Wards—Deare, Roper, Morrison.

Medical Ward Clerks—Burdett, Hine, Bryes, Bishop, Cock, Cockell, Hetch, Morgan, Moore, Rake, Shelswell, Stuart, Sturge, Reynolds, Gosse, Greves.

Assistant Surgeon's Dressers—Gruggen, Starling, Campbell, Sage, David, Scott, Atkin. Parkinson, Brett, Harper, Tabb, Ashwell, Perkins, Davenport.

Assistant Physician's Clerks—Williams, Downes, Crew, Haycroft, Whitworth, Wright, Sturge.

Obstetric Out-Patient's Clerks—Johnson, Gaylor, Austin, Pilkington, Barns, Williams, Wright.

Dressers in Surgery.—Anderson, Clay, Fenwick, Perkins, Pilkington, Smith, Wilson, Archer, Crosse, A. Lane, B. H. Lane, Luscombe, Marsh, Rowlands, Shaw, Erott, Williams, Prendergast.

Dental Surgeon's Dressers—Hills, Crook, Sanders.

Aural Surgeon's Dresser—Barns.

Post-Mortem Clerks—Archer, Otway, Studer, Phillips, Wood.

Surgical Ward Clerks—Anderson, Hills, Smith, Tabb, Clay, Fenwick, Pilkington, Smith, Wilson, Elliott Lane, A. Lane, D. H. Marsh, Mullis, Shillingford, Woodraffe.

Assistant Surgeon's Clerks—Rowell, Warner, Udale, Shillingford.

Externs—Scott, Burroughs, Brownfield, Flanagan, Rowlands

The following gentlemen have passed the 1st M.B. Examination (London):—*First Division*—Breedon (Liverpool and Guy's), Bassett (Birmingham and Guy's). Rake. *Second Division*—Marsh, Oram. Excluding Physiology, J. Smith.

GUY'S HOSPITAL GAZETTE,
AUGUST, 1878.

WE had occasion, a short time ago, to call attention to the numerous notices of Classes, Demonstrations, &c., which appeared on the notice board in the Colonnade during the late Session, and we gave them as evidence that there was plenty of work to be done in the Summer Session. We showed that all this was part of a method of teaching which the present development of scientific examinations demanded, and we also tried to show that this system of class teaching, apart from any idea of *Cram*, was likely to prove useful in studying medicine generally.

We have now to notice another of these signs of the times, if we may be allowed so to put it. We allude to the intention of the authorities to raise the fees for medical education at this School; the extent of the increase we believe, will be 25 *per cent.*, or the price of the Perpetual Ticket will be 125 guineas, instead of 100 as heretofore. Few amongst those who have watched the course of medical study during the last year or two will be at a loss to explain this, but many parents and guardians of October freshmen may be rather alarmed. The facts, however, that have led to this perfectly justifiable course are quite plain:—Firstly, there is the general statement, oft repeated but true, that medicine has advanced with rapid strides of late—more than ever now and increasingly every year, medicine calls to its aid Chemistry and Physics, and manifestly to its advantage. The ground thus covered by the man who wishes to learn his profession properly, is greater in extent and more complex than it was, say 20 years ago; consequently his method of study in a corresponding degree becomes more elaborate. He has to make more or less special study of Bot any Chemistry and Physics, and to assist him in these subjects he requires specialists or professors of Botany, Chemistry and Physics; they, in their turn, insist on his getting, if possible, an intelligent idea of their subjects, so they demonstrate, and to demonstrate requires apparatus. It is then a question of Demand and Supply, and the go-between is money of course, as in everything else, and we may at once state that no money is better spent than in the thorough education of the future medical man. From a political economy point of view, the demand for good well-educated medical men is increasing, and, we are bound to confess, is far greater than the supply, this, the experience of consulting Physicians and Surgeons fully bears out.

On the other hand it is said that a limited education, such as may be obtained by rushing through a Hospital Course in two or three years, is enough to fit a man for ordinary practice; well, let such men bury themselves in obscure country villages where they may quite undisturbed treat their patients on "general principles," and what they are pleased to call "common sense lines of treatment." But the tone of our profession is not to be raised in such a way, sheer knowledge and methods of applying it must do that, and if we are to accomplish this happy end we ought not to object to paying a little more for it.

INTERSTITIAL NEPHRITIS.

BY T. S. SHELDON.

PAPER READ BEFORE THE PHYSICAL SOCIETY, MARCH 23RD, 1878.

Continued from page 80.

A very vexed question in the pathology of granular kidney is the source of the connective tissue which is so abundantly present. So various are opinions, that in comparing two accounts of the pathological history, *e.g.*, as given by Johnson and Green or Rindfleisch, one can hardly credit the fact that they refer to the same morbid condition. To take one example:—Dr. Johnson says, "At no period of the disease is there enlargement of the kidney, but from the commencement a process of wasting occurs." Rindfleisch says, 'In the first stage the kidney is much enlarged." Green says, "In the early stage, if the process be acute, the kidney is somewhat increased in size." These quotations aptly introduce two well-marked theories as to the pathology of the connective tissue, and one cannot help half suspecting that each author had very strongly before his mind the dimension the kidney ought to assume, according to the particular theory affected by him.

Dr. Johnson says that in the healthy organ there is no connective tissue between the convoluted tubes, that the intertubular capillaries are in immediate contact with the basement membranes, which is the only connective tissue between the capillaries and intertubular epithelium; therefore, whatever increase of connective tissue there is, and it is less in granular kidney than in some large white or lardaceous kidneys, is not an intertubular, but a tubular thickening. In support of his view he quotes Ludwig's statement:—"No fibrillated connective tissue exists between the tortuous portion of the urinary tubules."

But because there is no fibrillated connective tissue it does not follow there is no connective tissue at all. Ludwig, in the

same place, says, "The connective tissue of the kidney does not everywhere exhibit the same structure; the fibrous capsule and the immediate investment of the large bloodvessels in the papillary portion of the medulla essentially consisting of the fibrillar form, whilst the labyrinth of the cortex and the limiting layers of the medulla chiefly consist of the cellular form of this tissue. Fibres also pass round the malpighian bodies."

Used as Dr. Johnson uses it, the first quotation is simply misleading, but taken with the context, as of course the writer meant, it says anything but that there is no connective tissue between the convoluted tubes. In short, Ludwig agrees with most histologists of eminence in describing an intertubular stroma containing connective tissue corpuscles. The weight of evidence being so greatly in favour of the view that normally there is intertubular connective tissue, one of Dr. Johnson's strongest objections to an interstitial growth falls to the ground. Stated briefly, his belief is this:—That on the degeneration and disappearance of the epithelium the tubes shrink; this shrinking goes on unequally, so that at a given moment there will be found some tubes devoid of epithelium; others similarly affected but more shrunken, and separated by wide interspaces of fibrous tissue composed of other tubes and capillaries in an extreme degree of atrophy. The thickening of the basement membrane of the tubules and of the melphighian capsules, and the atrophy of the glandular elements are to his mind sufficient to account for the microscopical appearances.

Leaving the dispute as to the normal histology out of the question, it is quite conceivable that this description may in the main correctly represent the facts of the case, and it therefore behoves us to inquire how far it may be acceptable to other pathologists.

Drs. Wilks and Moxon, like many others, regard chronic degenerative nephritis as a term resting on a supposition of which there is no sufficient proof; but from actual observation they are inclined to think that the connective tissue found is due to the atrophy of the tubules, there being, perhaps, a very slight increase round the vessels. Under high powers the patches of fibrous tissue are resolved into remains of tubes. From a very ingenious consideration of drawings by Dr. Dickinson, who opposes the primarily atrophic theory, they draw a conclusion similar to that which they think microscopical examination warrants. But having gone so far as to doubt strongly an interstitial nephritis and subsequent cicatrization, and yet not far enough to accept epithelial changes as primary and the cause of the atrophy, we are landed in a difficulty as to what *is* the cause. We can hardly conceive of a simple atrophy of the basement membrane of the tubules as the first anatomical change, and so are driven to look elsewhere. This "elsewhere" is suggested by Drs. Wilks and Moxon to be the malpighian corpuscles, whose closure may, they think, be the starting-point of the disease.

Charcot, in the passage already quoted, goes so far with Dr. Johnson that he regards epithelial changes as first occurring, but he thinks there is interstitial increase as well. As I pointed out, his reasons for this opinion seem to be based more on analogy than on observed facts, and are therefore not strong. Moreover, it seems to me that—without for a moment doubting the possible correctness of Dr. Johnson's desquamative theory—his arguments rest on a very narrow basis. In his lectures on Bright's disease the only proof offered is the statement that in some cases of gout, which afterwards die with granular kidney, granular casts—not necessarily epithelial—may be found in the urine during a paroxysm, without any change in the colour or specific gravity of the fluid, and without albumen. He argues, therefore, that epithelial changes can be the only ones that at this time exist. He describes neither the histology nor the naked eye appearances of the organ at this stage, but only when the disease is evidently far advanced.

Much more accurately stated is the theory which has furnished the name—Interstitial Nephritis. The details of the process, given by some pathologists, are conspicuously minute and well corrected. There is no awkward break in the story told by Rindfleisch. Briefly it is this:—In the first stage the kidney is enlarged; the capsule, thick and juicy, peels off readily; the organ is soft and doughy, and its surface of a whitish hue; on section, this alteration is found confined to the cortex, which is yellowish white, exsanquine save for its malpighian bodies, which look like red dots on a pale background. It bulges from the cut surface, while the medullary cones are either unaltered or only congested. To the naked eye it resembles the parenchymatous form of nephritis very closely, and some practice is needed before an observer can distinguish between the two forms; microscopical examination can never be dispensed with. It shows that the appearances in question are essentially due to a corpuscular overgrowth of the connective tissue in the region of the convoluted tubes and the malpighian capsules.

According to Dr. Dickinson this increase is most noticeable on the outer aspect of the organ, whence it extends inwards. In the second stage the kidney may shrink so half or less than half its normal size, but whether this atrophy be due to cicatricial contraction of the new tissue, plus disappearance of the textural elements of organ, or to the latter only without alteration in the quality of the connective tissue, may be queried. From microscopical appearances, with which I need not trouble you, Rindfleisch concludes that there is no cicatrization, but that the glandular structure atrophies through the simple pressure of the corpuscular overgrowth.

The time at my disposal is so short that it is obviously impossible to do justice to any one part of the subject without omitting much interesting matter elsewhere. I shall, therefore, not attempt to comment on the theory just started, but Chronic Bright's disease, according to different observers.

Dr. Bright noticed the fact that the left side of the heart was often hypertrophied, without valcular lesion to account for it. In sixty-three decided cases of granular kidney Dr. Galabin found hypertrophy in fifty-three, and Dr. Dickinson states that simple hypertrophy of the left ventricle is of rare occurrence in any other form of renal disease than Interstitial Nephritis. Various explanations of this circumstance have been offered. We have not got much beyond Dr. Bright's suggestion that "the altered quality of the blood so affects the minute and capillary circulation as to render greater action of the left ventricle necessary to force the blood tnrough the distant sub-divisions of the vascular system." Johnson describes a functional contraction, becoming organic, of the small arterioles which is excited by the passage of the impure blood through them. The circulation is thus hindered, and the heart is required to act more powerfully to maintain the circuit. Much exception has been taken to this view; as Dr. Galabin says, "It appears almost to attribute to heart and arteries an antagonism of intention, as if they were actuated by volition." In snpport of the theory I shall not do more than refer to a communication by Dr. Gowers to the *British Medical Journal* for September, 1876. There are described cases in which examination of the retinal arteries by the ophthalmoscope demonstrated a contraction of the vessels, accompanied by a hard radial and high-tension pulse. In his comments he shows that the arterial contraction is the cause of the high tension. Dickinson looks upon this communication as important. Atheroma is often present in granular kidney, aud Traube shows rather prettily that, according to Dr. Johnson's theory, this is a natural result of the increased pressure thrown on the elastic tubes intervening between the hypertrophied left ventricle and contracted arterioles. But some say the atheroma itself may cause the hypertrophy: however, out of twenty-three cases of what might be called uncomplicated atheroma, the heart was enlarged in thirteen, and its average weight was but 12½ ounces against an average

of 15 ounces for cases of granular kidney. Moreover, there is Bright's disease without atheroma, and yet with hypertrophy of the heart.

An attractive theory is that which regards the capillaries as the seat of obstruction. Dr. Reid's experiments showed that in asphyxia the altered blood either refused to pass the capillary system, or the capillary system did not consent to receive the blood; a modification of the capillary attraction between the blood and the blood-walls around. It seems very natural to suppose that a similar impediment is afforded by the capillary system in granular kidney; the pressure is raised in the arteries, and the heart accordingly has to work more vigorously: the effect on both is hypertrophy.

A somewhat similar view is held by Dr. Mahomed, but practically it is more interesting, as it renders intelligible the occurrence of albuminuria in granular kidney. To avoid misinterpretation I will quote:—"The changes which precede and accompany cirrhosis of the kidney are peculiarly insidious in their commencement, gradual in their development, and prolonged in their existence. There is, therefore, at first a slight but gradually increasing want of relation between blood and tissue; this produces a corresponding slight, but also gradually increasing, condition of high tension in the arterial system. This increase of tension is too slight and too gradual to produce an albuminuria, but it nevertheless, if allowed to increase, produces a thickening of the arterial walls, a hypertrophy of their muscular coats, and a hypertrophy of the heart. When at last this very gradual increase of pressure—which may require years for its development—reaches that degree, which, in an acute case with healthy vessels would give rise to a copious transavation of albumen, the walls of the capillaries and arterioles are so thickened that it is far more difficult to force through the albumen. For the same reason the hæmoglobin is absent from the urine of these patients, in whom the high arterial tension is invariably well marked. In such cases slight constipation or chill (by arrested excretion) will produce that temporary existence or increase of albuminuria, which is so characteristic of cirrhosis, or a more severe constipation or chill will immediately give rise to the symptoms of the acute form of Bright's disease."

All the authorities above mentioned recognise arterial hypertrophy on theoretical grounds; it now only remains to say that Dr. Johnson actually describes a hypertrophy of the muscular coat of the arterioles throughout the body, but specially noticeable in the kidney.

In connection with vascular changes we now come to the latest elaboration in the pathology of granular kidney—the arterio capillary fibrosis of Sir William Gull and Dr. Sutton. These observers differ from most of those whose names have been used in this paper, in that they look upon a granular kidney as an item only of a general degenerative change of the vascular system. To summarise, they find—That the arterioles throughout the body are more or less altered, the alteration being due to a hyalin-fibroid formation in the walls of the minute arteries, and a hyalin-granular change in the corresponding capillaries. This change is chiefiy outside the muscular layer, but is also in the tunica intima of some arterioles. Degree of alteration and extent of the diffusion of the morbid change vary in different cases. The muscular layer is often atrophied in a variable degree.

This hyalin-fibroid deposit is found in the renal vessels and intertubular parts of kidney; the tubular and intertubular atrophy, and the calibre of the arterioles is diminished. They are of opinion, moreover, that the heart andvessel changes have no constant relation to the amount of disease of the kidneys. There are three variations:—(1) Kidneys may be much contracted, heart much hypertrophied, arteris and capillaries proportionately thickened by hyalin-fibroid formation; (2) Kidneys may be little contracted, but vascular system in a similar condition to above; (3) Kidneys may be healthy, while the vascular system is affected. For these and other reasons they reject renal disease as the cause of the hypertrophy of the heart, but attribute it to disease of the vessels generally, their elasticity being impaired by reason of the morbid deposit.

The relation of this theory to the clinical history is a very interesting one, but time forbids the relation of it, as well as of the etiology, symptoms, and complications of the disease.

MEDICAL DEGREES—CAMBRIDGE.

In the present paper we shall proceed to consider the advantages held out by the University of Cambridge to those desirous of obtaining its medical and surgical degrees, and endeavour to point out as clearly as possible the manner in which they may best be employed.

At the outset it must be clearly understood that nine terms (3 years) residence at the University is required of all candidates for its degrees, whether medical or general, but this rule does not of necessity entail great expense owing to the non-collegiate system of residence at Cambridge which has of late years been greatly developed.

With this regulation in view the student of medicine will, if he is wise, employ his period of residence for the double purpose of obtaining a degree in arts as well as in medicine, especially as an almost identical course of study will qualify him for both, and believing this to be the best course to adopt we shall proceed to indicate the various means for its adoption.

Having determined to enter the University in October (as is customary at Cambridge), either as a non-collegiate student, or at one of the colleges—in which choice he will of course be influenced by pecuniary or other considerations—the student will probably be required to pass a matriculation examination in general subjects, this however is never very severe, and at some of the colleges is not enforced at all.

Of the Colleges which hold out especial advantages to medical students we may mention Caius and Downing, the former more particularly, not less for its medical than its social qualities.

At the end of the first term, *i.e.*, in December, the Previous Examination or Little-go may be passed in classics, mathematics and divinity, the special subjects in all being advertised for several months beforehand. Candidates for honours are required to pass in additional subjects comprising somewhat higher mathematics, whilst medical students are under all circumstances, required to pass in algebra before they can be registered for special medical study.

Having passed the Little-go with additional subjects the student may shape his course on three different lines—

1st.—He may proceed to his B.A. in honours, either by the Natural Science or any of the other

triposes, in which case he will not be troubled with any other examination in arts until he goes up at the end of his third year for the tripos.

2nd.—He may proceed to an ordinary B.A. degree, in which case he is required to pass an examination in general subjects at the end of his second year, and a final examination in a special subject at the end of the third year.

3rd.—He may proceed to a medical degree without taking a degree in arts at all. Of these alternatives, the first is undoubtedly the best to select, since it carries with it several direct advantages to the medical student, viz.:—a shorter period of medical study (4 years only being required instead of 5); an identical course of study as far as the preliminary scientific subjects are concerned; exemption from the first M.B. if honours have been obtained in Botany and Chemistry.

The 2nd mode of procedure is disadvantageous as the course of preliminary medical work (Chemistry, Anatomy, &c.) is greatly interfered with by the necessity for keeping up classical and mathematical knowledge to "examination standard" at the same time.

To proceed in medicine alone, the 1st M.B. may be passed after registration as a medical student, and due attendance on the University lectures in Chemistry and Botany.

The 2nd M.B., in Anatomy, Physiology, Zoology, and Pharmacology, may be passed after attendance on lectures in those subjects, and residence during four terms in the University.

The 3rd or final M.B. in Medicine, Pathology, Forensic Medicine, Surgery and Midwifery, follows after 5 years medical study (or 4 years in the case of graduates in honours), and the reading of any original Thesis on some medical subject before the University completes the curriculum for admission to the degree.

The M.D. degree is obtainable three years later without examination, but by Thesis in the same way as for M.B.

The only surgical degree conferred by the University is that of M.C. (Magister in Chirurgia). Only one examination is required, but the 2nd M.B. must have been passed. The subjects and mode of examination are very similar to those for the fellowship of the College of Surgeons.

The medical and surgical examinations are held twice a year, in June and December.

As regards the amount of medical study which it is advisable to attempt at Cambridge, we must remind our readers that a project is now under discussion for placing the University in a position to complete the medical education of students, but under the existing regulations we believe that the students will best prepare himself for future usefulness by confining his special studies at Cambridge to Chemistry, Botany, Anatomy, Physiology, Zoology, Materia Medica and Microscopic work.

In all these departments there will be found ample materials for practical work, with vigorous teaching and certainly more opportunity and encouragement for private study and research than is possible in a large London hospital.

Having passed the B.A. with honours in natural science, and also the 2nd M.B., the student will come to London better prepared for practical professional study, than if he had previously half-stored his mind with the ill-assorted and often incorrect ideas of medicine and surgery, which a casual attendance in the wards of a hospital is too apt to convey and which are often the hardest to unlearn.

UNITED HOSPITAL ATHLETIC SPORTS.

The 12th Annual meeting of the above sports was held at Lillie Bridge Grounds on Saturday, June 29th. The weather was all that could be wished for. At 12·30 the Representatives and Committee from Guy's started in a Drag from the hospital, the competitors being in good spirits and eager for the fray; they carried the shield with them, confident that the evening would see it restored to its former place. After an hour's ride the scene of contest was reached, and the shield was deposited among the other prizes.

At 2 o'clock the bell rang for the commencement of the sports, and at the same time the band of the Coldstream Guards under Fred Godfrey opened their programme with an overture (Fra Diavolo). Their fine playing much enlivened the proceedings during the afternoon, and gave great pleasure to a large number of spectators. No doubt the fineness of the weather as well as the certainty of seeing good sport attracted many. The ground was well filled, not only with students but there were present a great many ladies. We were glad to see the Hospital staffs well represented, and more especially Guy's. Thanks to the exertions of Messrs. L. Stokes, T. Shepherd and J. Fraser, who gained five events, the Shield was secured to us for the fifth time. The following are the results:—

100 *Yards Challenge Cup.*—1st Heat—H. T. Griffiths, St. George's, 1; J. M. Atkinson, London, 2; W. H. Addison, King's, 0; won easily. Second heat—R. S. Bond, King's, 1; J. Shepherd, Guy's, 2; this was a good race Bond only winning by half a foot. Third heat—H. M. Massey, St. Thomas's, 1; L. Stokes, Guy's, 2; won by a yard and a half. Fourth heat—R. J. Irwin, St. Bartholomew's, 1; W. J. Penny, King's 2; J. Hill, Charing Cross, 0, won very easily. Final heat—Bond, 1; Massey, 2; Griffiths, 0; Irwin, 0; had Massey started well he would have won, Bond won by 3 yards.

Throwing the Hammer.—J. Oxford, St. Thomas's, 81ft. 10½in, 1; E. Jennings, St. George's, 79ft 4in, 2; P. Boobbyer, King's, 0; J. A. Fraser, Guy's; had Fraser been in his usual form we should have won, but Oxford won with a throw of 81ft 10½in.

Hurdle Race, 120 yards, 10 Flights.—First heat—W. R. Pollock, St. George's, 1; W. H. Addison, King's, 0; T. R. Moorse, St. Bartholomew's, 0; Pollock led all the way and won by 10 yards. His style of taking the hurdles might be improved. Second heat—J. L. Lane, St. Mary's, 1; W. C. Collier, St. Bartholomew's, 0; Collier stopped half way and Lane finished alone. Third heat—F. Shapley, London, 1; W. H. Crosse, Guy's; C. G. Satchell, University; won by five yards, Guy's were not well represented in this race. Final heat—Lane, 1; Pollock, 2; Shapley, 3. This was a good race Lane and Pollock were almost level till the last hurdle, when Lane made a final struggle and won by a yard.

One Mile Challenge Cup.—V. E. Hunter, St. George's, 1; J. M. Banon, St. Thomas's, 2; M. Vivian, St. Thomas's, 3; Banon led till the last quarter of a mile from home, followed closely by Hunter, when at this distance from the finish, Hunter thought it time to exert himself, and coming away, won easily by 25 yards in very bad time.

Putting the Shot.—J. A. Fraser, Guy's, 33ft 10½in,; J. Oxford, St. Thomas's, 33ft 8½in, 2; S. Boobbyer, King's, 0; G. Cooke, London, 0; Q. R. Veitch, Guy's, 0; S. Watson, Charing-Cross. This was a good contest between Fraser and Oxford, the former only winning by two inches.

Quarter Mile.—L. Stokes, Guy's, 1; F. W. Humphrey, St. George's, 2; M. S. Wilson, King's, 0; H. B. Hoffmeister, St. Bartholomew's, 0; Hoffmeister kept the lead till the straight when Stokes with a splendid spurt passed him and won with ease.

High jump.—T. Shepherd, Guy's, 5ft 6in, 1; H. W. Shettle, St. George's, 5ft 5in, 2; H. M. Massey, St Thomas's, 0; J. M. Banon, St, Thomas's, 0; it was a good contest between the two first, but Shepherd succeeded in beating his opponent by 1 inch.

Half Mile Race.—F. W. Humphrey, St. George's,1; H. W. Yate, St. Mary's, 2; W. C. Collier, St. Bartholomew's, 0; J. Butler, St. Thomas's, 0; F. C. Fisher, St. George's, 0; Collier made the pace nearly all the way, but was run out at the finish and passed by Humphrey and Yate; between these there was a good race, but Humphrey succeeded in beating his opponent only by 3 yards.

Long Jump.—T. Shepherd, Guy's, 19ft 4in, 1; C. M. Luke, St. George's, 19ft 2in, 2; R. M. Athill, St. Thomas's, 0; F. W. Kendle, King's, 0; this again was a good struggle between the Guy's and St. George's, but Shepherd again was equal to the occasion and won by 2 inches.

250 *Yards.*—First heat—L. Stokes, Guy's, 1; R. S. Bond, King's, 2; J. Hill, Charing Cross, 3; this was a good race between Stokes and Bond at the start, but Stokes won easily by 4 yards. Second heat—R. J. Irwine, St. Bartholomew's, 1; R. H. D. Gwilling, St. Mary's, 2; W. R. Pollock, St. George's, 1; J. M. Atkinson, London, 2; won easily. Final heat—Stokes, 1; Irvine, 2; Griffiths, 3; Stokes won this easily, it was a good race between Irvine and Griffiths, aboot 3 yards separating them.

Three Miles.—F. A. Stone, St. Mary's, 1; V. E. Hunter, St. George's, 2; G. E. Forks, St. Bartholomew's, 3; A. D. Willcocks, King's, 0; H. C. Howard, St. George's, 0; G. R. Veitch, Guy's, 0; H. E. Archer, Guy's 0; J. H. Spong, Guy's, 0; H. Graveley, University, 0; Howard led for over a mile, when he gradually fell back and retired at the end of the second mile. Hunter and Forks now made the running, but Stone caught them up in the last lap and with a grand spurt succeeded in beating Hunter.

Strangers Race.—One mile handicap.—L. K. Holman, Belsize Foot Ball Club, Scratch, 1; W. Stephenson, L.A.C., 18 yards, 2; L. W. Swabey, St. George's, 75 yards, 3; H. Williams Ludbury, A.C., 110 yards, 0; Holman won by about 10 yards.

CHAMPION HOSPITALS.—1867, Guy's. 1868, St. George's. 1869, King's. 1870, King's. 1871, Guy's. 1872, Guy's. 1873, St. Bartholomew's. 1874, King's. 1875, St. George's. 1876, St. George's. 1877, Guy's. 1878, Guy's.

PAINLESS INJECTION OF MORPHIA.—In the *Student's Journal* it is stated that Dr. Allen has described a method for injecting morphia hypodermically, which gives little or no pain. The arm or leg is grasped underneath by the palm of the left hand, and the skin upon the upper surface is made tense with the fingers. The syringe is then to be inserted by a direct prick into the tense tissues, the former being held by the index finger and thumb. As it is said to be painless, it would seem from its simplicity to be at least worthy of a trial.

STATISTICAL REPORT OF GUY'S LYING-IN CHARITY FOR JUNE, 1878.

Number of women attended						191
No death.						
Of these there were in their 1st confinement					32	
,,	,,	2nd	,,		19	
,,	,,	3rd	,,		38	
,,	,,	4th	,,		20	
,,	,,	5th	,,		17	
,,	,,	6th	,,		21	
,,	,,	7th	,,		14	
,,	,,	8th	,,		9	
,,	,,	9th	,,		7	
,,	,,	10th	,,		6	
,,	,,	11th	,,		3	
,,	,,	12th	,,		1	
,,	,,	13th	,,		3	
,,	,,	14th	,,		1	
						191
Number of children born						194
Single births					188	
Twin births					3	
Number of premature children						10
Females dead					5	
Males dead					5	
Number of full time children						184
Males alive					89	
Females ,, ...					89	
Males dead					3	
Females ,, ...					3	
Presentations:—						
Vertex					184	
Breech					5	
Footling					3	
Left Knee					1	
Vertex and Funis					1	
						194
Externs attended:—						
Mr. P. Warburton Fuller					42	
Mr. P. A. J. Howell					38	
Mr. E. L. Brockliss					37	
Mr. Edward Penny					36	
Mr. A. E. Maylard					23	
Mr. H. Peskett					10	
Day, Casuals attended—						
Mr. Alfred, H. Burton					3	
Mr. W. H. Groose					2	
						191

In one case of contracted pelvis in which delivery could not be effected with forceps, the child was turned, the head being subsequently perforated behind the ear by the senior.

In another case of tedious labour, the B forceps were applied by the senior.

HENRY DAVY,
Junior in Charity for June, 1878.

TREATMENT OF WOUNDS.—M. Alphonse Guérin has, it appears, long practised an antiseptic method of dressing wounds, which has given admirable results. It consists in careful and minute cleansing of wounds by a strong solution of carbolic acid (1 in 5), and enveloping them subsequently in thick masses of fresh cotton wool, to act as a filter excluding septic germs. In an address delivered at the Académie de Médecine he gave details of his mode of treatment, alluding to the Listerian method, which he highly commended.

LONDON UNIVERSITY.

A short time ago there appeared in our *Gazette* an article on Oxford; being a short but admirable description of the course of graduation at the University. This was the first of a series of articles on graduation, intended to appear from time to time, for the benefit of those who propose going to one or other University.

The distinguishing feature of the University of London, consists, in its requiring no residence on the part of its graduates. Indeed, it consists of a body of men, with power, granted to them by royal charter, to confer degrees, after examination, in Laws, Medicine, Arts, Science, Music, and in such other departments of knowledge, except Theology, as they may from time to time determine. This non-residence meets the requirements of a large number of students, who find themselves from multiple and varied causes, unable to leave home or situation, to go and reside for a longer or shorter time at the English, Scotch, or Irish Universities, all of which require a certain period of residence. The examinations are open to all, the only restriction to matriculation, which is the first examination, and the one which all have to pass, whatever branch they may ultimately wish to take up, being, that the candidate must transmit a certificate to the registrar, at least fourteen days before the commencement of the examination, shewing that he has completed his sixteenth year. Graduates in Arts of the Universities of Sydney or Melbourne are exempted from the matriculation examination.

There are two examinations for matriculation in each year; one commencing on the second Monday in January, and the other on the last Monday in June. These examinations are held, not only at the University of London, but also under special arrangements, in other parts of the United Kingdom, as Manchester, or in the Colonies. The fee for this examination is two pounds. If the candidate fails the fee is not returned, but he can enter any two subsequent Matriculation examinations, without further payment. The examination is conducted by means of printed papers in Latin, English Language, English History, and Modern Geography, Mathematics, Natural Philosophy, Chemistry, and any two of the following three languages, Greek, French, and German.

The subjects for examination in Latin and Greek are announced one year and a half previously.

This examination is accepted (1) by the Council of Military Education in lieu of the Entrance Examination otherwise imposed on candidates for admission to the Royal Military College at Sandhurst; and (2) by the College of Surgeons, in lieu of the Preliminary Examination otherwise imposed on candidates for its Fellowship. It is also among those Examinations of which some one must be passed (1) by every Medical Student on commencing his professional studies; and (2) by every person entering upon Articles of Clerkship to an Attorney,—any such person Matriculating in the First division, being entitled to exemption from one year's service. Hence, having passed this examination is of great use, especially to the medical student; for it not only exempts him from the petty preliminaries of other licensing bodies, but is itself a splendid groundwork, as he will find afterwards for no candidate is approved of who does not show a competent knowledge in each of the subjects specified above. It is no use passing ever so well in five subjects, if the sixth does not come up to their standard. They pluck most vigorously regardless of rank, wealth or power, indeed, the examiners do not know the examinees, for each of the latter has a number which he writes on his paper at the examination, and the examiners only know the numbers and not the names corresponding, which are known only to the Registrar. We unhesitatingly recommend all who can afford the time, and who feel desirous of elevating themselves, to pass the Matriculation examination before entering a Medical school.

After matriculating, the undergraduate may take up law, Medicine, Art, Science, Music, &c., the regulations for which will be found fully and clearly described in the University Calendar, published every year, price 4*l*. We shall omit the rest and assume that our Matriculated student is graduating in Medicine. The next examination he is required to pass, is called the "Preliminary Scientific M.B, examination," and may be passed in twelve months after matriculation, or in six months if the latter was passed in January, and the candidate be seventeen years of age. The subjects of examination are Chemistry, Physics, Botany and Zoology.

The question always arises and is very perplexing to both students and their parents, guardians, or friends, as to whether after matriculating, entry should be made at once into a Medical school, whence he can go up for the Preliminary Scientific. We have found that in such cases enquiries are made, from friends, medical men especially, in the neighbourhood, men probably graduates of no University at all, and if so, certainly not of the University of London. They almost invariably advise that the young fellow should be sent to a Medical school at once, where he enters as a first year's man, and they urge that whilst he is getting up the subjects of the Preliminary Scientific, he can be learning the rudiments of Anatomy, &c. Their advice is well meant, but founded on ignorance, and if followed will almost invariably result in complete failure; one of two things generally happens; perhaps the most frequent result is, that the student is very fond of Anatomy and other subjects, pertaining to Medicine, spends much of his time on them, and towards the end of the year finds himself quite unprepared for the Preliminary, and does not attempt it. Some at once proceed with their medical studies giving up graduation altogether. Others try another year, and at the end of that find themselves similarly unprepared, or may be, go in and get plucked; the result in these cases is the same "giving up the University."

The other, but less frequent result, is, that the student finds himself fully occupied with the subjects of the Preliminary Scientific, and has enough common sense to stick to them, and not be allured to extraneous subjects, however seductive, and at the end of the first year passes the examination, only to find himself a second year's man at his hospital, without the experience of a first year's man. In other words, he finds himself handicapped twelve months, and has to compete at hospital examinations for prizes, and also for appointments, later on in his career, and instead of a brilliant curriculum, his hospital life is a failure.

Listen to what the University itself says, in the second paragraph under the head "Medicine."—Candidates for the degree of M.B. are strongly recommended by the Senate to pass the Preliminary Scientific Examination, "before" commencing their regular Medical studies, and to devote a Preliminary year to preparation for it.

We fully endorse this advice. The amount of work necessary to pass this examination is quite sufficient to keep any ordinary student hard at work for twelve months. Of course he can enter at some hospitals for the Science course, without becoming a first year's man, but as a rule this is not to be recommended if he has the opportunity of going to a good college, such as University College, London; Owen's College, Manchester, &c., where science is much better taught. After passing the Preliminary Scientific, he should enter a Medical school, and in two years present himself for the 1st M.B. examination, which takes place once in each year. The subjects of this examination are:—Anatomy, Physiology, Materia Medica, and Pharmaceutical Chemistry, Organic Chemistry. These are therefore the subjects he has to study and he will find two years by no means to long.

The only advantage accruing from entering as a medical student immediately after matriculation is, that if the Preliminary be passed at the end of the first year, the first M.B. may be attempted at the end of the next, and if passed will be a gain of twelve months. This is doing three years work in two, and is only very rarely accomplished. After

passing the first M.B. he must spend two more years at a hospital, attending certain courses of Lectures, &c., and then he presents himself for the second or final M.B., and is examined in General Pathology, General Therapeutics, and Hygienic Surgery, Medicine, Obstetric Medicine and Forensic Medicine. On passing this he has graduated as Batchelor of Medicine. He may now go in for Bachelor of Surgery, (B.S.) and in twelve months, at the earliest, he can obtain the M.B., or if he has taken the B.S., he may graduate to the highest degree M.S. (Master in Surgery).

After each examination, subsequent to matriculation, those who have passed can present themselves again for Honours, and if sufficient merit be evinced, various exhibitions, scholarships, and medals are awarded. There is no examination for honours at the matriculation, the Pass list being divided into three divisions., viz:—Honours, 1st division, 2nd division.

The 1st, 2nd and 3rd in the Honours division, if they obtain the requisite numbers of marks, receive exhibitions for two years, of the value of thirty, twenty and fifteen pounds, per annnm, respectively.

Hence, it will be seen, that the very shortest time in which it is possible to graduate in medicine is practically four years; and occasionally it has been done in this short time. But five years is a very short time to do it, the large majority taking six years or longer. For it must always be remembered that every failure means twelve months longer, except the matriculation, which nominally only puts back six months, though even then it generally spoils the Preliminary for the following year, and so it amounts to twelve months.

Any one who wishes for further information should buy a Calendar, which can be had through any bookseller.

Correspondence.

"SIMILIA SIMILIBUS CURANTUR."

TO THE EDITOR OF *Guy's Hospital Gazette.*

SIR,—I should esteem it a favour if you would kindly insert in your most interesting *Gazette* the following brief remarks upon a law of therapeutics, which by some has been considered as being all important, by others as so irrational as to be unworthy of the attention of men of Science.

I am a M.R.C.S. and L.S.A., and undergraduate (1st M.B.) of the London University, and have passed the 1st F.R.C.S., and have spent six years at Guy's Hospital.

It seems to me that I have some right to speak of the theory of Medicine, as I believe actual practice is likely to have rather a narrowing effect upon the mind. For I believe that those who have been long in practice get to think too much of their own cases and too little of the experience of the profession at large; whereas a man with a basis of scientific knowledge and without any prejudice can afford to look about him and consider the various general principles upon which the practice of qualified medical men, whether orthodox or heterodox, is based.

Also as not one of my relations is a doctor, I am quite unbiassed and have seen a good deal of homœopathic practice as well as the six years of orthodox practice at the hospital.

The following remarks were suggested by the perusal of, but not in any way copied from, a most interesting short sketch of the Laws of Therapeutics by Dr. Joseph Kidd, recently published. It was almost necessary in order that the truth or the untruth of the law *Similia Similibus Curantur* should be demonstrated that a special set of men, naturally calling themselves homœopathists should arise, who practised almost exclusively on this one principle.

Unfortunately many of these men, instead of trying by minute scientific investigation, and by experimentation on animals to find out the actions of drugs on the healthy body, gave themselves over to absurd irrational infiinitesimal dosage and paid little attention to science of any sort. This cast a slur on those practitioners, so strong that up to the present day it remains as firm as ever.

But now a rational definition of the principle is given, and a large number of cases collected proving the truth of the law of similars in certain cases.

Medical men are now asked not to practice exclusive homœopathy, nor to use absurd infiinitesimal doses, nor use a peculiar pharmacopœia, nor special chemists, but in certain suitable cases to use ordinary drugs in ordinary doses, but on the homœopathic principle.

The law *Similia Similibus Curantur* may be explained on the following theory:—If a drug produces certain phenomena in a healthy person, and if phenomena very similar are produced by a particular disease, it is perfectly logical, rational, and scientific to believe that in all probability this drug acts particularly powerfully and specifically on the same organs as the disease, not however producing the same effects but similar effects, and as two similar, but different processes very rarely go on at the same time in the same organ, it is very reasonably hoped that the drug may have an alterative and curative effect by acting upon the actual and exact seat of the disease.

This law, even if true, is of course not of universal application as diseases arising from an infinity of different causes require treatment on an immense number of different principles.

Because one believes that the law of similars is true in certain cases it does not in the least prove that it is wrong to use drugs to antagonise certain symptoms and to increase others. It would be like saying that the law of gravitation could not be true, as a heavy gas-like carbonic acid rises in the air by the law of diffusion.

It would be perfectly rational to treat a case of disease on several distinct principles; thus a case of chronic ophthalmia with frontal headache and constipation. A purgative might be given to mechanically unload the bowels, and if this was not sufficent to remove the headache, an opiate might be given at night to relieve pain and procure sleep, a local astringent application to contract the dilated bloodvessels, and two or three drops of the liquor Arsenicalis B.P. given three times a day to act specifically on the conjunctiva according to the law of similars.

If there is nothing illogical in the statement of this principle, and if a number of facts seem to the unprejudiced mind to prove its truth, why should its advocates be considered as either fools, quacks, or humbugs?

It would be glaringly false and absurd to say that it is the only true principle of treatement, but if true for certain cases it is a most important help to the selection of the right drug, and should henceforth be used as one of the numberless methods which physicians possess of treating disease.

Such a surprisingly bigoted state exists in the orthodox Medical World against this principle that I dare not sign my name, as I have not yet obtained my degree at the London University.

I am, Sir,

Your obedient and humble Servant,

AN UNDERGRADUATE.

TO THE EDITOR OF *Guy's Hospital Gazette.*

SIR,

The following may interest or amuse some of your numerous readers.—

While staying lately at a small Hotel on Loch Maree, Ross-shire. I found out something of the Highland notion of Therapeuties, through a conversation which I had with the Proprietor (a tolerably well-educated highlander) who was suffering from Palpitation of the Heart.

On his request that I should give him something for his complaint, I asked if he had any medicine in the Hotel,

"Oh yes," was his prompt reply, "we have some of that 'Gregory Powder.'" I mildly suggested that, that was an excellent remedy in appropriate diseases, but did not meet his case.

He then said he had got a number of pills "some large, some small, some black, and some all silvery"; when asked if he knew of what they were composed he said that when first he had them, they were in a large box with named compartments, but that his dog had got at the box and broken it and "mixed" the pills, and that now he did not know one from another, but was very much surprised at my being in this respect as ignorant as himself, and thought me almost mad when I suggested that he should throw them all away.

It has been necessary to send the prescription which I wrote for him a distance of thirty miles to the nearest chemist.

I have discovered since that the natives in this part of the world have two remedies (specifies ?) for all diseases, they are

1.—Whiskey.

2.—A pound of fresh butter melted and swallowed while warm.

I presume the first is taken only to counteract the effects of the second, which may be better imagined than described.

I am, Sir,

Faithfully yours,

JOHN MACKERN.

NOTES OF THE MONTH.

WE hear that all the Candidates from Guy's for the Matriculation at London University in June last were unsuccessful.

PRIZES.—The following is the result of the examinations recently held:—*First Year*—W. E. Dendy, 1; E. L. Adeney, 2; E. H. Booth, 3; G. A. Mahomed, Certificate. *Second Year*—W. E. Fielden, 1; G. R. Marsh, 2; J. W. Sanders, Certificate; R. J. H. Scott, Certificate; E. A. Starling, Certificate; J. J. Udale, Certificate. *Third Year*—H. E. B. Flanagan, 1; L. E. Wooldridge, 2; J. T. J. Morrison, Certificate.

THE Treasurer's Gold Medal in Medicine has been awarded to G. H. Russell, Proxeme Accessit. H. E. B. Flanagan.

NO AWARD of the Treasurer's Gold Medal in Surgery has yet been made.

BOOKS, ETC., RECEIVED:—Phosphates in Nutrition, Aids to Chemistry (Part II.), Medical Press and Circular, Sanitary Record, Students' Journal, Proceedings of Medical Society of County of Kings.

N.B.—IN future all communications respecting advertisements and business matters of the *Gazette* are to be sent to A. SCOTT, Esq., Guy's Hospital.

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GUY'S HOSPITAL GAZETTE,
SEPTEMBER, 1878.

ACUTE CYSTITIS, WITH SLOUGHING OF VESICAL MUCOUS MEMBRANE.

UNDER THE CARE OF MR. DURHAM.

Family history.—Unimportant.

For the last five months has had great pain in the back, and trouble about her bladder. A week ago she found that she was not able to micturate, and therefore sent for a medical man, who came and passed a catheter, and continued to pass one twice a day up till the time of admission into the hospital.

On Admission.—June 4th.—Patient was carried into the hospital and admitted into Martha Ward. She complained of frequent desire to micturate, but inability to do so; also of great pain and weight about the hypogastric and iliac regions.

On Examination.—The bladder was full, reaching nearly as high as the umbilicus; great pain on suprapubic pressure. Catheterism gave great pain, and about one pint and a half of very offensive urine, mixed with blood and mucous, were drawn off.

Treatment.—Hot fomentations to abdomen,

℞. Pot. Cit., gr. x.
Tr. Buchu., ʒj.
Liq. Morphiæ., ♏iv.
Decoct. Sennæ., ʒj., t. d. s.

Diet.—Milk, ice, and brandy.

June 5th.—Complains of great pain in the bladder, and a frequent desire to pass water, but unable to do so. A catheter passed twice daily, and the bladder was washed out with permanganate of potash. The urine is very offensive, and contains much blood.

June 6th.—Feels better, but still complains of a scalding pain in bladder, and a frequent desire to micturate. Slept well, appetite bad, bowels irregular.

June 7th.—Patient being under chloroform and placed in lithotomy position, Mr. Durham examined the bladder for calculus, but was not able to detect one. This then left only villous growth or acute cystitis to account for the symptoms. The urine was now drawn off, and was the colour of blood and very offensive; some was examined under the microscope, but no evidence of villous growth.

℞. Pot. Bromidi., gr. x.
Pot. Cit., gr. xx.
Tr. Hyoscyami., ♏. xv.
Inf. Matico., ʒj., 4ts horis.

The bladder to be washed out three times daily with this lotion:—

℞. Boracis, Sodii Chloridi } á á ʒ., fl. pulv.

In one pint of water:—

Inject.: Hypodermic, Liq. Morphiæ., gr. ⅓; hac nocte.

June 8th.—Complains of forcing pains and frequent desire to pass water; could get no sleep on account of pain in the bladder. Tongue furred; P., 120; T., 98·4°. Bowels open. Urine still very offensive, and the colour of claret while it is being drawn off. The catheter has to be withdrawn two or three times on account of it becoming blocked with clotted blood.

June 12th.—Feels no better; treatment the same; urine still in the same condition; P., 96; T., 98.4°.

June 13th.—Patient states that the pain in the bladder has passed off, and the desire to micturate is less frequent. Slept better. P., 84; T., 98·°. Urine still very offensive, of blood colour, and contains much mucous.

Evening.—Great pain in abdomen; had Pil. Opii., gr. i., which gave relief.

June 14th.—Slept well after pill; still complains of pains in bladder; has violent vomiting, which increase very much the pains in bladder. Bowels open. Tongue furred; P., 96; T., 98·4°.

June 17th.—No sickness; condition of urine the same, also the treatment. P., 100; T., 98·4°.

June 18th.—Complains of weakness and inability to turn in bed; pain in bladder not so great; the sickness has returned. P., 96; T., 98·4°.

Afternoon.—Patient being under chloroform and placed in lithotomy position, Mr. Durham proceeded to dilate the urethra. On being sufficiently dilated he passed his little finger into the bladder, and said that it felt like villous growth. He then introduced dressing-forceps and procured some of the supposed growth, which on examination proved to be sloughing mucous membrane. She was returned to bed, and ordered the previous treatment to be continued:—

Pil. Opii., gr. i.; hac nocte.

June 19th.—Complains of pain in bladder and urethra; urine dribbles away, but not sufficient to relieve her, is still very offensive, and contains mucous and clots of blood. Bowels open. P., 100; T., 98·4°.

Evening.—Patient became suddenly cold, fainted, and was unconscious for half an hour. The application of hot water-bottles and warm blankets brought her round. On recovering consciousness she complained of sickness with great pain in bladder; about half-a-pint of very offensive urine was drawn off, being the usual dark colour:—

Enema Amyli with Tr. Opii., ♏xx.; statim.

June 20th.—Is very weak this morning; sickness still continues, as also the pain in the bladder. Bowels open. P., 108; T., 98·4°.

℞. Pot. Bromidi., gr. xx.
Tr. Opii., ♏x.
Sp. Am. Aromat., ʒ gr.
Aq. Camph., ʒj.; 4ts horis.

June 21st.—Is much worse and apparently sinking. Has had violent nausea all night; urine in the same condition; is obliged to discontinne medicine, and is only able to take ice and brandy.

Afternoon.—Gradually losing voice, and has not the power of retching, but complains of desire to be sick. Mr. Durham saw her and ordered—

Quiniæ Disulph., gr. v.
As Hypodermic Inject.

Boracis } á á 5j.; ft. pulv.; pro inject.
Phosph. Ac. }

Bladder to be immediately washed out with this lotion.

June 22nd.—Died at 2 a.m.

Autopsy.—No peritonitis. The bladder, urethra, and kidneys were removed together. The bladder was opened, and the whole mucous membrane was found detached inside. The muscular fibres were exposed, and of a blackish colour. Pus was found in both ureters. The right kidney was healthy, but the left showed minute points of pus, the suppuration extending through the centre. There was no perinephritis in either kidney. The uterus was tilted forwards. The ovaries were healthy, as also the other viscera.

[We are indebted to Mr. Edwin Roper for the above.]

CASE OF ENTERITIS AND TUBERCULAR PERITONITIS.

WITH REMARKS BY DR. GOODHART.

(*Continued from page* 86.)

"Both Brinton and Wilson Fox refer to the double perforating ulcer, and they notice this peculiarity of the disease, that though the single ulcer on the posterior surface of the stomach is more common than the single ulcer on the anterior surface, yet the latter is found more frequently perforating than the former; and this is explained by the readiness with which the posterior surface of the stomach adheres to the loose structures with which it is in contact behind, and from these the base of the ulcer derives such support as prevents its perforating. According to Brinton's figures the ulcer on the anterior surface perforates about 85 times in 100 cases. It would be naturally expected that when there are two ulcers, one an anterior, the other a posterior, the risk of perforation would be greatly increased. But this is found not to be so; the double ulcer has a third less tendency to perforate than the anterior alone.

"The fact of there being a posterior ulcer seems to diminish, as Brinton states it, the usual tendency of the anterior ulcer to undergo perforation. Why it should be so it is very difficult satisfactorily to explain. It is also very difficult to understand how a young woman with two ulcers in her stomach should have enjoyed to all appearance perfect health, and whose body after death was described as having been robust and well nourished; such a body as presented no evidence whatever of having suffered from disease, the characteristic symptoms of which are 'pain and vomiting, hæmorrhage, disturbances of the digestion, and alterations of the secretions of the stomach.'—(Wilson Fox.)

"Specimen No. 2 was removed from the body of a servant-maid, aged 34 years, who, while out walking on a Sabbath evening, was seized with what she termed cramps in the stomach. To relieve the violent pain she had administered to her some brandy. With the aid of a friendly arm she, with great difficulty, reached home. At a late hour at night the assistance of the family doctor was obtained, and on his arrival he found the woman suffering from general peritonitis. In twenty-two hours the case had ended fatally. On inquiring into the history of the woman it was ascertained that she had been for a considerable period in service, and was always fit for her duties, although at times she had what was termed a bad stomach. There were two things which the woman could not take without vomiting; the one was tea, the other was beer. In this case there was an obscure suspicion that possibly some drug had been administered for the purpose of procuring abortion. On post-mortem examination a large irregular shaped perforating ulcer was found on the anterior surface of the stomach, and within the abdominal cavity there was a considerable quantity of fluid. There was otherwise abundant evidence of general peritonitis. The woman had not been pregnant. The edges of the ulcer were thick and indurated, and it evidently had existed for many months. There had not been any hæmorrhage; the emaciation of the body showed, however, that there had been great disturbance of the powers of digestion.

"Specimen No. 3 was removed from the body of a man who had been about forty years of age, and who had died suddenly from peritonitis and collapse, after partaking of a hearty meal. So far as the history of the case could be ascertained from the friends of the deceased, he was not known to have had any symptoms of gastric ulcer.

"On post-mortem examination there was found on the anterior surface of the stomach, immediately below the ensiform cartillage, a small opening, looking as if punched out, about the size of a fourpenny-piece, with its edges smooth, vertical, and sharp. There did not appear to have been much inflammatory action in the mucous membrane, and the opinion was expressed that the ulcer had been probably of recent origin, and that perforation was caused by over distension of the stomach, the peritoneal coat having become greatly attenuated by the destructive powers of inflammation.

"Specimen No. 4 was very typical of the conical ulcer of the stomach so graphically described by Brinton. It was of small size, and situated on the anterior aspect of the stomach, but nearer the cardiac end than any of the other specimens already described. It was removed from the body of a girl aged 18 years,

who had been occupied in a warehouse in town, in sewing with a sewing machine. Shortly after her return home from work, and after partaking of tea and bread, which was her usual diet, she was seized with pain in the stomach. At first the pain was not so violent as to cause her to take to her bed or to seek assistance. During the course of the evening, however, it had increased; but instead of the pain being felt in the region of the stomach, it was complained of low down in the abdomen and over the bladder. This fact led the medical attendants to suppose that the case was one of acute inflammation of the bladder, due, probably, to rupture of that organ. In consequence of the frequent desire to void urine and to aid in the diagnosis of the case, a catheter was cautiously introduced into the bladder, when a small quantity of clear urine was drawn off.

"Symptoms of peritonitis continued for about twenty-four hours, when she died in considerable agony.

"The post-mortem examination revealed not only a perforating ulcer of the stomach, but showed that the peritonitis had been more acute and extensive in the pelvis than in any other portion of the abdominal cavity. This was probably due to the fact that when perforation took place, and for several hours afterwards, the girl had been on her feet and moving about, and the fluids as they issued from the stomach found their way at once and rapidly into the pelvic cavity, the lining membrane of which became first inflamed. The inflammation soon extended to the peritoneal coat of the bladder and uterus.

"It was learned that the only symptom of gastric irritation which the girl was known to have had was pain in the stomach after eating a full meal. There never had been any vomiting of food or blood, but there had been amenorrhœa. During the inspection it was remarked that the internal organs were somewhat displaced, and that the waist was very small. It is a question how far tight lacing may have acted as an exciting cause of the ulcer in the stomach.

"Specimen No. 5 was removed from the body of a married woman aged 34 years, who was pregnant of her fourth child. She had been complaining of pains in the stomach, and had sent a little girl to a druggist's shop to purchase some cream of tartar. Instead of cream of tartar the girl was served with tartaric acid. Without observing the difference between these substances, the woman dissolved a full teaspoonful of the acid in a teacupful of water and drank it off. Shortly thereafter her stomach became distended and violent pains then ensued, which lasted about twenty hours, when she expired. The ulcer was a large one, fully the size of a penny-piece, with thick indurated edges. Its shape was irregular, and it was situated near the pylorus. In this case there had been the history of pain in the stomach, accompanied by emaciation, but there had been no vomiting of food. A portion of fluid removed from the abdominal cavity was subjected to chemical tests, and it was stated that these indicated that tartaric acid was present. It may be remarked, however, that it was known that the woman had taken tartaric acid instead of cream of tartar before the post-mortem examination was made.

"Specimen No. 6 was an ulcer in the descending colon. Death had been due to peritonitis from the passage of fæcal matter into the abdominal cavity. The ulcer had been about the size of a sixpenny-piece, and its edges were slightly indurated. There was no other ulcer or other evidence of disease found in the body. Around the ulcerated opening, and limiting a small quantity of fæcal matter which had escaped from the interior into the peritoneal cavity, was a small abcess. This specimen had been removed from the body of an English gentlemen, who had died in an hotel in the city, after suffering considerable pain for several days. There was a suspicion, which proved, however, unfounded, that he had been intentionally poisoned."

The first of these cases is peculiarly interesting as showing how easily suspicious circumstances may be chained together without their warranting any conclusion adverse to the reputation of anyone.

I return to our case. The following is the account of the post-mortem:—The post-mortem showed changes which had not been expected. The peritoneum was reddish-looking all over, but I could not satisfy myself that there was any definite peritonitis. Still, patients die very often with all the symptoms of anteperitonitis, and yet next to nothing to show for it, so I could not say that this patient's symptoms were not due to peritonitis: they may have been. For the rest, the only lesions that were found were in the intestine. The stomach was healthy—bear that in mind, please, because on that fact alone is based an important inference as to the question of irritant poisoning. The intestine did not show much externally, except that some parts were more injected than others; but when opened and examined from above downwards there struck us first of all a small part of one of the larger valvulæ conniventes, which was raised shaggy looking, yet firmer and more substantial than the surrounding mucous membrane, and considerably ecchymosed. Further down other similar patches were observed, and then they got larger and more irregular in size, less definitely shaded off from the adjacent healthy mucous surface. Then there came ulceration. The most intense disease was in the ileum, though some was near the ileocœcal valve, and in the cæcum also was a very severely affected part. Both these were extensive surfaces of submucous extravasation of blood, and with a central irregular-eyed ash-grey slough, which had not got separated. Peyer's patches and the solitary glands were not visibly affected, and notwithstanding the severity of the disease in the parts which were attached, there were many parts, indeed, the greater

part, of the intestine which looked quite healthy; the diseased patches being widely separated by healthy mucous membrane. The morbid appearances were therefore those of a peculiar and intense enteritis.

Now the case is one of considerable variety, and I shall therefore allude very shortly to some others similar, which may throw light upon it. There are several somewhat similar cases in our post-mortem records:—

1. A man was admitted with albuminuria and extreme amyloid disease of the intestine and other viscera. Ten days before death diphtheria of the fauces attacked him, and the day before death he became speedily collapsed. A part of the ileum was gangrenous, and the mucous membrane above it intensely inflamed and diphtheritic. There was general peritonitis.

2. A woman, aged 21, was admitted with what was thought to be typhoid fever. There were rose spots, but which at the post-mortem were noticed to be larger than usual. There was acute peritonitis, and the mucous membrane of the colon was universally ragged, dirty, grey, and sloughing.

3. A man of 37, with a large cirrhosed liver, showed a diphtheritic inflammation of the ileum and extreme ulceration of the cæcum.

4. A boy of 9 died of pyæmia after amputation of the thigh, and the cæcum and the colon were found much inflamed; the ridges of mucous membrane being covered by fine granular lymph, and the mucous membrane ulcerating in parts.

5. A man, aged 23, was admitted with purpura and died rather suddenly; the abdomen being tense, tympanitic, and tender. The last part of the ileum was acutely inflamed with lymph on the surface, and looking as if it had been strangulated; the mucous membrane being toughened, irregular, and shaggy. There was ulceration near the ileocœcal valve.

6. Another man, a publican, with cancer of the cervical glands and viscera, had dysenteric diarrhœa a few days before death. The end of the ileum and large intestine were of dark colour and injected, the glands prominent, and a little granular lymph adherent.

7. A woman, aged 26, with bad kidneys and phthisis, had diphtheritic inflammation of the last two feet of the ileum and ulceration of the colon.

8. A man, aged 20, got wet through with a cold and cough. He was very ill on admission, with the general appearance of typhoid fever, but no rash. He also had pneumonia. Diarrhœa was present, but the character of the stools was not noticed. He died with typhoid symptoms in nineteen days. The whole length of the large intestine was actually inflamed, soft, swollen, and velvety; lined with mucous and tenacious lymph. There was ulceration in various parts.

9. A woman, aged 57, died from a strangulated hernia in 1857. Purgatives, including croton oil and *shot* had been administered to overcome the obstruction, so it is no matter for wonder that in the whole length of the colon and the lower three feet of the ileum the mucous membrane was greenish brown and hidden by a layer of lymph.

10. A man, aged 62, was seized on August 6th with vomiting and purging, continuing up to August 11th, when he was admitted collapsed and with thin tender abdomen and imperceptible pulse. He had diarrhœa. There was acute peritonitis, and the intestines were dark red in blotches.

11. Some years ago I recorded this case in the "Transactions of the Pathological Society." A man, aged 36, under Dr. Moxon's care, a labourer, who had lived well, after a sore throat of three weeks' duration felt worse when cleaning out a boiler ten days before admission. He had a purpuric rash upon his skin and other anomalous spots unlike anything found in any described disease, and his condition was not named. He had no fever at first, but afterwards the temperature rose to 103°. He lived about six weeks. The uvula was found sloughing, and the small intestine also throughout; Peyer's patches being often quite healthy.

12. Since then I have seen other cases, one in a woman under Dr. Wilks, with ex-opthalmic goitre, a weakly subject, aged 22. She had a good deal of diarrhœa in the course of her illness, and generally some fever. Towards the close of her life, which was rather rapid, an abscess formed in the axilla. Except diarrhœa she had no abdominal symptoms, yet the whole of the small and large intestine was much injected, and the surface for the most part superficially ulcerated, covered by adherent lymph and thick mucus; Peyer's patches were a little swollen, but nowhere ulcerated.

13. And the last case was that of a man, 47 years old, under Mr. Howse for malignant pustule. He was ill fourteen days, and had some looseness of the bowels, but no other abdominal symptoms, and the actual conditions were unsuspected. At the post-mortem there were several tracts of the small intestine much infiltrated, thickened, superficially ulcerated, and in a condition of intense enteritis.

Enteritis is usually treated of in books as of three kinds:—catarrhal, diphtheritic, and phlegmonous. That is a division which has the merit of simplicity, and is wonderfully satisfying at first sight. But somehow or other—whether the effort to be clear so exhausted the writers' energies that they never told us much more, or that such a simple classification so fills the learner with its sense of sufficiency that it seems unnecessary to learn any more on this subject, this I know, that there are few subjects we know less about—I mean have precise and accurate knowledge of, as to the symptoms of the varieties, their causes, and their relationship than enteritis.

You will all recognise the truth of this if you think

for a moment of what you are prepared to say supposing I ask any one of you individually what he knows about enteritis. Surely I am not wronging you by saying that you would not tell me very much, or if you want a stronger testimony, I have just told you of thirteen cases and not one of them was diagnosed before death. Not one of them. There is no evidence, so far as I can find out, that the nature of the case was even suspected in any one. A very strong proof this that we know, at any rate, very little about the disease, and a strong ground also for my calling your remembrance to the fact by devoting an hour to its consideration.

Now the symptoms of enteritis are usually given. What are they?

Of the *catarrhal form:* Aching and griping abdominal pains, nausea and sickness, diarrhœa and tenesmus, with the passage of abundant soapy or watery mucus; fever.

Of the *diphtheritic*, or, perhaps better, pellicular form, because there is no evidence that all pellicular inflammations are of the nature of diphtheria. The symptoms are not special, they are mostly those of colic-diarrhœa or dysentery.

Of the *phlegmonous form:* This difference is noted, that whereas diarrhœa is the prominent feature of the two former, in this variety, from the greater severity of the inflammation, the diseased parts of the bowel become paralysed, their canal dilated by the accumulating contents, and the bowels constipated. Constipation and vomiting are thus present in place of diarrhœa and vomiting. There are also the abdominal pain and tenderness of peritonitis with the tormina of colic. The temperature is usually high, the features pinched, and death may take place rapidly.

But you see the difficulties of diagnosis in such cases, because the first two varieties have very little distinction, and of them I shall say no more than that the one is, whatever its cause, the immediate forerunner of most of the diarrhœas we meet with, especially in children, and occurs under such a variety of conditions that it would be impossible to formulate them; and the other is particularly liable to occur in Bright's disease. Bristowe also adds cirrhosis and cerebral disease. The case now immediately before us, however, was one of the third form of phlegmonous enteritis, and that has precisely the same symptoms as acute peritonitis—abdominal pain, meteorism, vomiting, and constipation. One symptom, however, may be of value, and that is the amount of fever. If present, and usually it is so, then you may suspect something beyond simple peritonitis, which, as all agree, has very little effect in elevating the temperature. It does not, of course, follow that the absence of fever will render the presence of enteritis improbable, because the peritonitis may become the predominant disease in any case of enteritis, as it is in this, and acute peritonitis tends, as is well known, to produce collapse or subnormal temperatures. But fever and peritonitis indicate some complication, it may be enteritis, or typhlitis, or pneumonia, or the formation of pus in the peritoneum; not lymph only, or serum.

In this case there was nothing whatever to guide one to a diagnosis of anything more than peritonitis, as it was one of the most acute cases, without fever, with much collapse, and speedy death.

But in looking over the other cases I have mentioned, and adding thereto from others mentioned by Dr. Dickinson in the "Transactions of the Pathological Society" (eighteen cases in all), there are one or two points which are of some value for putting one on a right scent in future cases.

I have arranged the cases thus:—

With typhoid or purpuric rash on the skin	4
With suppuration in some parts of the body (pyæmia), one being a case of Charbon	4
Very acute, with no discoverable cause (? blood-poisoning)	3
With renal disease (amyloid in 3) . .	4
With cirrhosis of the liver . . .	1
With cancer of the viscera . . .	1
After hernia and purgatives . . .	1
	18

Now you must bear in mind that these are rare cases, so that small numbers mean a good deal more than they would do otherwise. Therefore, first, I attribute some importance to the fact that four have had peculiar eruptions upon the skin in the course of the illness; and as the outcome of this, whenever I see a patient with fever, and with any anomalous rash not corresponding to the usual forms for those fevers now well recognised, I always think of the possibility which exists of the presence of enteritis. I am bound to say that at present it has not helped me to the diagnosis of a case, but I am in hopes that it will do so some day.

(To be continued.)

IN most public institutions the scanty wages paid preclude the possibility of employing as nurses any but such as are either imbecile, incompetent, or of more or less questionable character. Every one responsible for the management of such institutions has felt the need of improvement in this regard, has perhaps been induced at times to overlook moral delinquencies on the part of nurses of fair ability, rather than incur the risk of filling their places with these less efficient, though perchance more honest or virtuous. Until better wages are paid, this want of good nurses in infirmaries, nurseries, hospitals, and asylums must continue to be a serious evil, and the sick and unfortunate be subject to the tender mercies of those to whom a considerate man would not willingly entrust a valued horse or a valued dog.—DR. EDSON *on* "*Good Nursing*."

MARRIAGE.—On August 6th, at Hempsted Parish Church, near Gloucester, by the Very Rev. Sydney Turner, father of the bridegroom, assisted by the Rev. J. Crocke, Alfred Moxon Sydney Turner, to Mary Sophia, daughter of R. W. Graves, Esq., F.R.C.S., of Gloucester.

GUY'S HOSPITAL GAZETTE,
SEPTEMBER, 1878.

THE perusal of the valuable outlines of the various University courses which have lately appeared in the *Gazette*, naturally leads one to ponder:—First, Is there any use in taking a degree at all? Second, Which degree is the best to take? As regards the first question, we emphatically answer, Yes; and we believe that any one who impartially considers the matter will give a similar reply. A medical man, who has passed a University course, takes a higher position in the profession than one who limits himself to the usual qualifications. But many will be found who look on the matter in a different light—"My father never took any degree and he gets on well, why should I?"; or again, "Leave degrees for consultants and those who aspire to the staff of a hospital; what good is a degree to a general practitioner? Few of the general public have much idea of what degrees are, and care little whether you have one or no." True, but do not be too sure of the ignorance of the public. When paterfamilias settles in a new abode, if he be a sensible man, what does he do? He pays a visit to some medical friend, and asks his advice as to the best doctor for his family in the new town. The medical register is taken up, and the advice given is probably based on the tale it tells. The better the examinations passed, the better the doctor, is certainly not always the case, but such a maxim will not often lead far astray.

Granted then, that it is best to take some degree. At which University shall it be taken? The answer will depend to a large extent on the perseverance, the abilities, and the resources, as regards time and money, of the embryo-student. To the fortunate possessor of plenty of money who is not pressed for time, we would say, take your degree at Oxford or Cambridge. The time spent there in preliminary study will never be regretted. You give there the delicate finishing touch to your classical education, and, above all, you gain a position which is seldom attained by those who pass direct from school to Hospital. The London degree is attainable by any man of fair ability who is resolved to do his best, and is more suitable than that of the resident Universities, for him whose time is somewhat limited, and his pocket perhaps more so. But here a word of caution, let no one attempt the examinations at Burlington House unless he is determined to persevere; for he will have to work hard, and not unlikely he may suffer a defeat now and then, even though his armour may have been well burnished.

Respecting the degrees of Edinburgh, of Aberdeen, of Brussels, we will say little. That of Edinburgh is good and scarcely inferior to those of Oxford and Cambridge; but why go North when you have a University just under your nose, which will give you a degree if you only work for it?

If you want to be a M.D. with a mininum amount of trouble, by all means go to Brussels, you will have a pleasant trip, a nice examination, and when you come home, will at least be able to call yourself "Dr." with *an easy conscience*.

IT seems likely that, at length, the outcry for "Hospital Reform" is to have some practical result. The Vicar of Battersea has, we are informed, purchased a house and grounds on Wandsworth Common, which he intends to convert into a hospital for such patients as can afford to pay something for their maintenance and treatment. Of the amount of remuneration, and other practical details, we are as yet uninformed, and all we can do at present is to give publicity to such a praiseworthy scheme.

Want of space will not allow us to enter into all the arguments for, and against, this much debated subject, and all we shall do is to enquire how it affects us as medical men. Before going further, we would most strongly advise that each patient should be allowed to choose his own medical man; so that every medical practitioner should be able to treat his own cases in the hospital. By so doing practitioners would feel assured of not being robbed of their patients, and in this way the co-operation of the profession would be gained for the scheme while yet in its infancy. By this plan also, the standard of medical science would be raised, namely, by keeping its members in communication with some Hospital, and so tending to prevent that stagnation into which it is so terribly easy to fall after our student's days are over. Again,

what an immense boon would it be to the practitioner to be able to place his "interesting cases" under a Hospital roof, where he could feel sure that they were properly nursed, and that his treatment was carried out in its entirety.

And as students how would it affect us? Would it tend to damage the schools? At the first glance the answer would seem to be in the affirmative. Here would be undeniably a chance of our beds and out-patient rooms being somewhat emptied. But yet, when we come to think of the number of absolute and unthrifty poor who cannot pay, of the still greater number of those who can, but will not pay, we believe that there will be plenty of cases left to stock our beds and out-patient departments.

But even granting that such would be the case, that our school would be bereft of their former practice, yet the gain to the newly qualified men would be immense, owing to the number of House Surgeoncies, Clinical Assistantships, &c., which would be thrown open by the new scheme; the advantage of which to the junior members of the profesion cannot be overrated. Taking all things into consideration we believe that we should be rather gainers than loosers. There is yet one more consideration and which, though not affecting us as medical men, does so most strongly as young bachelors doomed to live in London "diggings." The misery of a long illness in London lodgings, with all its accompanying want of good nursing, feeding, companionship, &c., can only be realised by those who have personally experienced it. How many a young clerk would gladly go to such a home, who now naturally shrinks from entering an ordinary hospital. For this reason alone, if for no other, we would urge on the public the necessity of such institutions.

That there will be many difficulties and obstacles to be overcome before the new system is raised to a state of efficiency we, as men connected with hospitals, know only too well. That the very choice of medical men, which we have advocated, will cause many an unpleasantness, many a trouble, we have no doubt. But, still, we believe that in the end the thing may be done, and done well, and we therefore wish the Vicar of Battersea all success in his arduous, but most laudable undertaking.

CEREBRAL LOCALISATION.

(*Concluded from page* 77.)

Irritative lesions of the motor area due to meningoencephalitis, syphilis, tubercles, cicatrices of old wounds, &c., have been also shown by Dr. Hughlings Jackson to produce convulsions limited to certain muscles or monospasms when invading these regions, and Dr. Ferrier states that monospasms, or convulsions beginning in this way and becoming generalised, are always due to an irritative lesion in the motor area of the opposite hemisphere. The lesion producing the monospasm is found to be in that part of the motor area which is indicated in the experiments above mentioned as presiding over the movements of the affected muscles.

Corpus Striatum.—When the corpus striatum is irritated in monkeys there is general muscular contraction on the opposite side, pleurosthotonos being thus produced. This is accompanied by opisthotonos and tonic contraction in the muscles of the face, whilst the limbs are maintained in a flexed condition. Movements, due to the action of one muscle, or of one group of muscles, cannot be produced by direct application of the electrodes to the corpus striatum itself. It would seem, therefore, that the complex motor impulses originating in the cortex of the motor area of the brain pass along the radiating fibres to the corpus striatum, that here they influence the centre, co-ordinating the different muscles by which the movement is to be effected, being transmitted thence to the spinal nuclei on the opposite side, to the influence of which the movement is immediately due. Destructive lesions of the corpus striatum in man produce hemiplegia on the opposite side, sensation remaining unimpaired.

Occipital lobes. — Neither irritation, destruction, mutilation, nor removal of the occipital lobes in the monkey produced any effect on sensation or voluntary motion. The animal "could see, hear, touch, taste, and smell as before; and could walk, run, jump, and use its limbs with perfect power and co-ordination. The functions of circulation and respiration were likewise unaffected." Such are the observations of Dr. Ferrier. Some changes were at the same time observed to occur. The unwillingness to eat and loss of appetite were found to be greater than after operations as severe, or even more so upon other parts of the brain, though the appetite for drink was not similarly impaired; this, in Dr. Ferrier's opinion, was owing to the sensation of thirst being due to a dry condition of the fauces, the local expression of the general bodily need of water, whereas hunger is due to the local condition of the stomach being an organic or visceral sensation. Dr. Ferrier therefore suggests that the occipital lobes may contain the centre of visceral sensations, these being distinct from tactile or cutaneous sensations which he localises in the hippocampal region.

He also thinks that Dr. Hughlings Jackson and Dr. Bastian may be right in associating disease of these lobes with mental obtuseness and defective memory, a not unfrequent consequence of disease in the occipital lobes, but he does not consider this as in any way proved.

Corpus Callosum.—Irritation of the convolution of the corpus callosum (gyrus fornicatus), or of the corpus callosum itself, produced in monkeys no outward manifestation.

SENSORY REGIONS.

It has been already mentioned that the sensory tract, upon reaching the brain, passes through the posterior third of the internal capsule, and destructive lesions in this part have been shown to produce hemianæsthesia on the opposite side, tactile sensation being affected up to the middle line of the face and trunk. Both skin and mucous membranes are anæsthesic, and the hearing, taste, smell, and vision are impaired, and in rare cases abolished. The viscera remain sensitive to deep pressure. The cause of this anæsthesic would seem to be interruption to all the paths of the sensory impressions, which probably reach localised centres through this expansion of the crus, the sensory fibres being connected with the optic thalamus, corpora quadrigemina, and corpora geniculata, whence the fibres radiate to the grey cortex of the posterior portions of the brain.

Optic Thalamus.—Since the sensory tracts of the cord pass specially along the upper or posterior portion (tegmentum) of the crura cerebri into the optic thalami it would seem probable that they are the ganglia of these tracts, and specially connected with sensation. The experiments of Dr. Ferrier confirm this indication, and total destruction of the optic thalamus in the monkey was followed by paralysis of sensation on the opposite side of the body, seemingly due to the lesion in the thalamus, and not to the injury to other parts which its destruction involved. No motor manifestations were produced by electric irritation of the thalamus. In the experiments of other observers (Vulpian, &c.) similar effects were not produced by this lesion, this being due, as Dr. Ferrier supposes, to the fact that the optic thalamus was not *totally* destroyed, such destruction being necessary that unilateral sensory paralysis may be produced.

Dr. Ferrier believes the sensory centres, which are "differentiated" in the hemispheres, to be "integrated" in the optic thalami, the motor centres being similarly "integrated" in the corpus striatum. Thus "organic nexuses" are established, so that actions involving at first thought and attention, come to be performed, as it were, automatically, the impressions made on the organs of sense travelling up to the optic thalami, and thence directly to the corpora striata, instead of making the larger or conscious circle through the sensory and motor centres of the hemispheres. This is what usually happens in animals, while in man it seems to be only the most habitual actions that are thus performed.

Angular gyrus.—Irritation of the angular gyrus produced ocular movements, the head and eyes being moved towards the opposite side with an upward or downward deviation, according as the anterior or posterior limb of the gyrus was stimulated. There was also a tendency to closure of the eyelids. Destruction of the gyrus on one side produced blindness in the opposite eye, only temporary in this case, but permanent if the gyrus on the opposite side was also destroyed. These facts led Ferrier to suppose that the pli courbe or angular gyrus was the centre of vision, and that all the fibres of the optic nerve had decussated before arriving there, as already mentioned.

TEMPOROSPHENOIDAL LOBE.

Dr. Ferrier believed the superior temporosphenoidal convolution to be the centre of hearing, since its irritation in the monkey was followed by pricking up of the opposite ear, wide opening of the eyes, dilitation of the pupils, and turning of the head and eyes to the opposite side, the same phenomena as were produced by a loud sound in the opposite ear. There seemed to him to be the "outward manifestations of the arousal of subjective auditory sensation;" this convolution being the centre of auditory sensation, calling forth movements through the corpus striatum, or perhaps associated in action with a centre in the frontal lobe, as already mentioned.

The hippocampal region (hippocampus major and uncinate, or superior occipitemporal convolution) was believed by Dr. Ferrier to be the centre of tactile sensation, irritation of this region causing restlessness and uneasiness as if from some uncomfortable sensation, while its destruction impaired or completely destroyed tactile sensibility. Since nearly the whole outer surface of the hemisphere could be destroyed successively without loss of the sense of touch, whereas when this region was involved sensibility was affected, and perhaps abolished, Ferrier was induced to regard this as the tactile centre.

The subiculum cornu ammonis, or tip of the temperosphenoidal lobe, is supposed by Ferrier to be the centre of smell, as already mentioned, not only from its anatomical connection with the olfactory nerve, but from the fact that irritation of this part in the monkey gave rise to "a peculiar torsion of the lip and partial closure of the nostril" on the same side, which he regarded as the outward expression of subjective olfactory sensation. Similar movements occur when a powerful or disagreeable odour was applied to the nostril, confirming this idea, and destruction or injury to the subiculum was found to diminish or abolish the sense of smell on the same side.

Irritation of the lower part of the middle temporosphenoidal convolution produced in the monkey move-

ments of the lips, tongue and cheek pouches seeming to be reflex movements due to gustatory sensation, as if the centre of taste was situated here. This, as Ferrier remarks, would explain those cases in which blows on the head, specially on the vertex or occiput, are followed by temporary or permanent loss of taste and smell, the cause being probably, as Dr. Ogle suggests, injury by counterstroke to the antero-inferior parts of the cerebral hemispheres, or, as Dr. Ferrier supposes, to these parts where the centres of smell and taste are in immediate relation to each other.

It seems that in many cases lesions of these sensory regions have been found in man, while no symptoms had existed corresponding to the above indications. Thus extensive lesion of the sphenoidal and occipital convolutions has existed without sensory paralysis, an abscess involving the anterior and inferior part of the temporosphenoidal lobe without special symptoms, and other similar affections in this part of the brain with nothing but the general symptoms of cerebral abscess. Dr. Ferrier believes this to be partly, if not entirely, due to deficient observation. By Meynert and others chronic epilepsy has been attributed to a lesion of the hippocampus.

Corpora Quadrigemina.—Irritation of the corpora quadrigemina was found by Dr. Ferrier to produce such movements of the trunk and limbs as are required for the preservation of the normal attitude and for progression. Thus in fishes, the tail and fins; in birds, the wings; and in mammals, the trunk and extremities are moved. If the optic lobe or corpora quadrigemina are destroyed on one side, blindness of the opposite eye results; destruction of one eye causing similarly atrophy of the opposite tubercle. These facts, and the anatomical connection of the optic nerves with these bodies, have led Serres to look upon them as the centres of co-ordination of retinal impressions with special motor reactions, while the angular gyrus is regarded by Dr. Ferrier as the centre of conscious vision. Destruction of both corpora quadrigemina both causes locomotor inco-ordination and abolishes vision, and the pupils then cease to contract when light is thrown on the retina. This permanent dilatation of the pupils is probably due to the action of the sympathic nerve on the dilating fibres of the iris, no dilatation being produced after division of the cervical sympathetic, and it may be the outward expression of sensory irritation which is known to produce this effect. Irritation of the corpora quadrigemina produces contraction of the pupils, probably through the influence of the third nerve, the nucleus of which is situated below those bodies.

Adamm found that stimulation of the nates or anterior corpora quadrigemina produced ocular movements, stimulation of the right side producing movements of both eyes to the left, of the left side movements to the right, &c., stimulation in various parts causing various movements, depending on the spot stimulated. It therefore seems probable that their function is to co-ordinate the ocular movements when the eye is employed in vision. Irritation of the posterior tubercles excites at the moment of application of the electrodes, a short sharp cry, as if these might be the centres of responsive re-action between stimulation of the sensory nerves and the larynzeal mechanism concerned in vocalisation.

FUNCTIONS OF THE CEREBELLUM AND MEDULLA OBLONGATA.

Cerebellum.—Though the functions of the cerebellum are still uncertain, it seems probable that its chief function is to combine and harmonise (co-ordinate) the muscular movements which the ordinary actions involve, specially, if not entirely, those determining the position of the body, and maintaining its equilibrium. Flourens had remarked this to be its special function in his experiments on both birds and mammals, lesions of the cerebellum being found to produce disharmony of movements, and to cause disorders of equilibrium resembling those due to intoxication. Motor power, sensation, and volition were unaffected. Dr. Ferrier's experiments led him to the same conclusion, and he remarked that while to-ordinated combinations of muscular contractions may be willed and excited as before, after injury to the cerebellum they are no longer co-ordinated with the position of the body in space, and hence when the animal attempts to move it reels and staggers helplessly.

Both irritative and destructive lesions of the cerebellum cause disorders of equilibrium. Thus in monkeys, cats, dogs, &c., a lesion of the anterior or posterior part of the middle lobe caused the animal to fall forwards or backwards, destruction of the lateral lobe causing it to fall laterally, these movements being, in Dr. Ferrier's opinion, those which it would be the function of the affected part of the cerebellum to counteract if in a healthy state. Stimulation of these parts would produce therefore the converse movements. He looks upon the maintenance of bodily equilibrium as a responsive action due to co-ordination in the cerebellum of tactile, visual, and labyrinthine afferent impressions, interference with any of which causes marked disturbance of equilibrium. The effect of perversion of the tactile impressions he represents as being well shown in the phenomena of locomotor ataxy, believing the inco-ordination to be due to interruption in the transmission of impressions of contact by the posterior columns of the cords, owing to a schlerotic change in those parts. Thence the ataxic symptoms, thence the difficulty in maintaining equilibrium. That the symptoms are not due to loss of cutaneous sensibility is proved by the fact that such loss may exist without impairment of co-ordination, nor do they seem to be owing to loss of muscular sense (consciousness of the state of contraction and force exerted by the muscles), which is

derived from centripetal impulses generated by muscular contraction, but may exist quite independently of it. The effect of visual impressions being lost is seen in the same disease, closure of the eyes much increasing the difficulty in maintaining equilibrium, and to the same cause may be attributed the usual want of steadiness in motor adjustments when light is withdrawn or when the eyes are shut.

With respect to the labyrinthine impressions, Dr. Ferrier believes the cerebellum to be connected with the ampullary branches of the vestibular division of the auditory nerve, impressions from which would reach the cerebellum through the restiform bodies as already indicated. That the semi-circular canals influence locomotor co-ordination is proved by the effect of experiments, and by the symptoms of Menière's disease. Thus a lesion of the superior canal causes a tendency to fall forward, of the posterior to fall backwards, of the external or horizontal canal to fall laterally; the effects thus corresponding to those due to lesion of the anterior and posterior part of the middle lobe, and of the lateral lobe of the cerebellum, with which they would probably be respectively connected. Menierè's disease, it will be remembered, is a disorder in which there is vertigo, and the patient feels as if he were suddenly thrown forwards, or backwards, or laterally, staggering and perhaps falling in the direction which corresponds with his sensation.

Menière has shown that disease limited to the semi-circular canals will produce these symptoms, the tendency being to fall to the right if the disease affects the left horizontal ampulla, backwards if the superior, and forwards if the posterior canal. This tendency to fall has been proved to be due to increased tension in the ampulla of the canal, the endolymph then exerting more pressure on the ampullary dilatations of the canals over which the nerves are spread. Dr. Ferrier looks upon the actions due to the semi-circular canals as compensatory like those of the cerebellum, and as being made with the object of preventing a tendency to fall in the opposite direction, and that Menierè's disease is an irritative affection of the canals giving rise to movemeuts which are the exact converse of those due to lesion of the same, being therefore their normal compensatory movements. It is thus that irritation of the superior semi-circular canal, as in Menierè's disease, by inflammatory exudation will stimulate it, and produce a tendency to fall backwards (a lesion of the same canal producing a tendency to fall forwards, which it is the normal function of this canal to counteract). Falling backwards produces increased tension in the ampulla of the superior canals, and diminished tension in those of the posterior canals, these variations acting as a stimulus to the posterior part of the middle lobe of the cerebellum, which would prevent backward displacement of equilibrium by calling into action the flexors of the head and trunk.

According to Dr. Ferrier the optic nerve would probably be connected with the cerebellum by means of its superior peduncles, or the valve of Vieussens, which is contiguous to the corpora quadrigemina; the general surface of the body by its lateral peduncles and the pons varolii, and the auditory nerve by means of the restiform body, and it would be by means of these connections that the visual, tactile, and auditory impressions would reach the cerebellum, and enable it to maintain equilibrium.

The theory of Gall that the cerebellum is the seat of the instinct of propagation has been proved by pathology and clinical experience to be erroneous; the nervous centres connected with the generative organs being probably seated in the lower part of the spinal cord. Curiously enough a tumour in the cerebellum was the cause of Gall's death, the amative propensity having been always strongly marked in him.

Medulla Oblongata.—This portion of the encephalon contains the following most important centres:—

1. The centre of respiration, situated in the lower part of the floor of the fourth venticle, near the origin of the vagus. Flourens has termed this part the "rœud vital," since if it be excised or injured death ensues instantaneously. Its rhythmic action is partly reflex, the afferent impulses being in this case probably started in the lungs by the condition of blood in the pulmonary capillaries, or possibly the altered air in the air-cells being in such a condition as to stimlate the peripheral endings of the vagus; it is partly automatic, being due to the effect of the blood on the respiratory centre itself.

2. The vasomotor centres, placed on each side of the median line on the floor of the fourth venticle, and reaching almost from the calamus scriptorius to the corpora quadrigemina. The tonic character of the blood vessels and the blood pressure are maintained by this centre, so that if the cord be divided below the medulla all the arteries of the body dilate, and the blood pressure fall to a low point.

3. The centre of innervation of the heart, whence inhibitory nerves pass to the heart through the pneumogastric and accelerator nerves by the spinal cord and sympathetic.

4. The centre of deglutition, higher up than that of respiration, the afferent impulses extending along the glopopharynzeal, but also along branches of the fifth nerve, and along the pharynzeal branches, and superior larynzeal division of the vagus. The afferent impulses pass along the hypoglossal, glopopharynzeal; vagus through the pharynzeal plexus; fifth and facial nerves to the different parts of the mouth, pharynx, and œsophagus.

5. The diabetic centre occupies the same part of the bulb as the vosomotor centre. It was discovered by

Claude Bernard that by pricking the floor of the fourth venticle in this part glycosuria was produced within two hours, and lasting from a few hours to a day or two. He believed this due to excessive conversion of the glycozen existing in the hepatic cells into glucose or grape sugar, with which the blood becomes loaded, much passing away in the urine. It seems probable that this part of the floor of the fourth venticle (seeming to coincide with the vaso-motor centre) influences in some way the diameter of the vessels in the liver, the impulse passing along anterior columns of the cervical, and, perhaps, dorsal spinal cord through the sympathetic tracts which are there placed, and thence in some way to the liver. The hepatic vessels are thus dilated, and the functional activity of the liver being increased by the consequent hyperœmia, glycosuria supervenes.

MONTAGU LUBBOCK.

THE TEACHING OF PATHOLOGY AT GUY'S.

Perhaps no medical school or hospital in Great Britain presents to the student a more extensive or more readily accessible amount of material for pathological investigation and research than Guy's, having, as it has, in round numbers, its five hundred or more post-mortem examinations in the year; yet how few men one sees evincing even the smallest interest in this all-important department, and, perhaps, the large number of that few taking up the subject just casually till some examination or other is passed, and then giving it up again. Now is this lack of workers in this department due to want of intrinsic attractions in the subject itself, or is our system of teaching at fault? We fear we must look entirely to the latter for an explanation of the present state of things. It is surely not necessary in these scientific and enlightened days to dilate once more on that almost trite subject—the importance of a knowledge of the appearances of diseased organs and tissues after death. Who would ever have known anything of such diseases as emphysema of the lung, phlebitis, softening of the brain and spinal cord, and, in fact, the whole host of organic diseases of the nervous system had it not been for post-mortem dissection? Pathology has enabled us to separate into specific diseases some affections which formerly were constantly confounded together, both in diagnosis and treatment, as the different species of inflammation of the lungs—pleurisy, pneumonia, and bronchitis; the different diseases of the heart, &c. Let it be remembered that we are discussing only morbid anatomy as distinguished from morbid histology. The latter is still veiled in some amount of obscurity, and, perhaps, is not essential to the making of a well-informed practitioner of medicine. But, on the other hand, we hold that no man ought to consider himself qualified to practice his profession unless he is prepared at any moment to make a thorough and satisfactory examination of the dead body, and to pronounce a reliable opinion upon, at least, the more common changes produced by disease. Anyone who will observe the almost ludicrous evidence given at times in the courts of law by even men of high repute in our profession, cannot fail to recognise the importance of knowledge on this subject, and the sorry exhibition one is liable to make if ignorant of it. The student may—and we fear does frequently—say to himself, "Oh, I can read up all these different appearances, and be very well able to recognise them at once without visiting that unsavoury institution—the post-mortem room." But it is not so. One might as well attempt to pass an examination on human anatomy without having dissected the body. Thus we hope to have shown that pathological anatomy can have some attraction for even the least scientific and enthusiastic of our fellow-students.

While, however, acquitting the subject itself of want of merit, we fear we cannot do so in the case of the system of teaching it at Guy's. We believe that all authorities will agree with us in saying that the teaching of pathology ought to be placed upon the same level of importance as systematic medicine or surgery. How can one have any true knowledge of medicine and be ignorant of the condition on which the very diseases we observe and profess to treat are dependent? As in anatomy, physiology, medicine, and surgery, pathology is best to be taught first by systematic lectures, and, secondly, by demonstrations on the dead body. The first, we may be allowed to say, we have only in name. *Eight* lectures, we believe, are given at nine o'clock on eight Saturday mornings during the summer session. This needs no comment. It is obvious to everyone that it is simply a *pro forma* treatment of the subject to satisfy certain examining bodies. Some hold, we know, that this deficiency can be made up by attendance in the post-mortem room. With this we cannot agree. First, the attendance in the post-mortem room is not nearly what it ought to be; and, secondly, we think it is impossible to give, in the short time that can be allotted to each case, a concise description of the changes found. Besides, having once fully discussed a certain morbid process in the class room, it is unnecessary to do more than note its presence or absence in the case under examination. Accordingly, we suggest that a course of lectures on general pathology should be given by one of our own very able pathologists during the winter session, of not less than sixty in number, attendance on which should be as compulsory as on any other course of lectures.

As to the method pursued in the post-mortem room, we fear our suggestions will be of too sweeping a nature to render their adoption probable. The present post-mortem room is far too small, and could not possibly be more inconvenient for the purposes for which it is intended. At present, just a few men only in one corner can see anything of what is going on, while they are at any moment in danger of a shower bath from intestines being washed out under their noses. Without further delay, and, at the same time, inwardly doubting the probability of its ever being done, we would suggest the entire re-arrangement of the post-mortem room, if not its rebuilding. In addition to this radical change we would also suggest the adoption of the following procedure under any circumstances:—

1. The different organs to be handed round in suitable trays or vessels for the inspection and manual examination of every student.
2. The post-mortem reports—so far as possible—to be dictated at the time of examination by the pathologist, and written by the post-mortem clerks.
3. That attendance in the post-mortem rooms be compulsory for an hour on each day that examinations are made by all students in the third winter and summer sessions.

The first, second, and third suggestions could be easily carried out without any serious trouble.

These changes in the lectures and demonstrations are, after all, not extensive; the subject itself deserves them, and we believe they would not press hardly upon either teachers or students.

Time and space forbid our entering upon a detailed defence of our propositions. We believe, incomplete and bare though they be, they would in a great measure tend to impart new life into the study of pathological anatomy among us. In conclusion we will only quote a few words once spoken by the late Dr. Hodgkin, the founder of our School of Pathology. He said, "To those who place the *summum bonum* of medical practice in converting the largest quantity of physic into

gold, morbid anatomy must, I am aware, be an object of disgust rather than attraction; but those who are aspiring to become the worthy members of a profession which has for its object the restoration of health, must see that morbid anatomy constitutes a study most essential to their art. I can see no palliative for the presumption of those who profess to administer even without the knowledge of the disease. Amongst such a class, however, must those be placed who are regardless of morbid anatomy.*

ANTISEPTIC DRESSINGS.

It has frequently been urged by the uninformed opponents of Antiseptic Surgery, perhaps when more cogent objections have fallen to the ground, that the expense of the dressing places it beyond the reach of ordinary patients in private practice. After some experience of Mr. Lister's work we are convinced that at the conclusion of any serious surgical case the expenditure will be much less under the antiseptic than under, what may now be termed, the old-system of dressing wounds.

Having some time ago arrived at this conclusion we have been much surprised, nay almost shocked, at the prodigal way in which the gauze is used in the wards of Guy's. We could mention, were it necessary for our purpose, many cases where the amount of gauze used for a single dressing would have been we are sure, quite ridiculous in the opinion of Mr. Lister himself.

For instance, perhaps for a simple pin hole puncture, six yards or more of gauze (we are speaking now of the large superficial dressings only) 37 inches wide applied; or again, an amputation or a compound fracture dressed two or three times a day with perhaps thirty or forty layers of the material.

Now we venture to suggest that at the very least half this quantity might as well have been stowed away at the makers in Glasgow as on the patient, for the use it could possibly have been in preventing the putrefaction of discharge on the access of septic particles to the wound.

We have seen numerous cases of a severe nature such as excision of the thyroid body, operations on bones in their continuity, &c., under the plan of dressing followed by Mr. Lister, and in no single instance do we remember to have seen more than sixteen layers of gauze used, and perhaps that on only one or two occasions immediately after operation and where considerable oozing of blood or serum might be expected. (By the way, we should be glad to know whether the cases in which the excessive dressing is used are always free from putrefactive odour.)

The reason for this is not far to seek, Mr. Lister we believe always uses an impermeable outer layer of macintosh and above all pays careful attention to the fixing of the dressing. For instance, in a wound of the knee joint it is absurd to place the greater part of your dressing on the anterior surface of the limb, for it is evident that the great bulk of the discharge will accumulate below at its posterior surface, or again in cases of excision of the breast, to place a large dressing on the anterior surface of the chest while all the discharge is lying unprotected, it may be, in the axilla.

This rule, that discharge will always accumulate at the most dependent part of the dressing is frequently overlooked. It is no good to employ thirty or forty layers of gauze to prevent the putrefaction of discharge with which they can never come into contact.

As to the use of the macintosh, whether from that very prevalent weakness to modify for good or for evil, every operation and every procedure one wishes to adopt, or from conscientious objections we know not, but one practically never sees this useful and cheap adjunct to the dressing used.

We have searched and enquired in vain amongst those who discuss it for a valid objection to its use, and the only ones we are able to find are those given by Mr. Howse in the recently issued volume of the reports. Mr. Howse there says, "As regards the use of the macintosh I object to it because it unnecessarily confines the secretions of the skin, and this increases the risk of eczematous eruptions under the dressings. That pure air should be allowed free access to the skin (filtering as it were through the carbolic gauze dressings) seems to me an essential element in our success." As to the actual fact of the occurrence of eczematous eruption from gauze, no one doubts that they do at times occur, but we think perhaps not frequently enough to be of any serious consequence, and Mr. Howse himself admits that under the macintosh the risk of their occurrence is only increased, thus implying that the risk exists under either condition. The second objection we do not understand.

The advantage to be claimed for the macintosh are, we believe—

1.—Carbolic acid at the temperature of the body is a fairly volatile substance, hence it follows that in dressings where the macintosh or some impermeable medium is not used, a considerable percentage of the antiseptic escapes without influencing the condition of the wound or it discharges in the least, and so a relatively large quantity of gauze has to be used.

2.—It diffuses the discharge over the whole extent of the dressing whereas when it is not employed the discharge soaks through the dressing opposite the wound, and thus not only are the peripheral portions of gauze not used but a serious source of putrefaction introduced.

3.—It enables us to use a much less quantity of gauze than we otherwise would, and is in itself an inexpensive material. The macintosh (that made with thin calico is the best) will with care last many times, two or three pieces only being necessary to complete a great number of ordinary cases.

Mr. Lister, in whose hands, we believe, the original dressing has been attended with greater success than any of the various modifications of it introduced by one surgeon or another has seen no reason at present for discarding the macintosh but rather looks upon it as a very important element in the dressing.

SPECIALISM.

It is characteristic of all large educational institutions that they should above all things reverence and adhere to the traditions and teachings of their leaders, both past and present, and we may safely say that our hospital forms no exception to this rule. Men leaving Guy's to enter into practice at the end of their course of study have only themselves to blame if they eventually find themselves ignorant of any branch of their profession, even though during the whole of that time they should have rigidly closed their eyes and ears to any but "Guy's teaching." But knowing and fully believing this, we would nevertheless endeavour to point out a few advantages that may follow a judicious employment of a short time, at least, in the study of certain branches of the profession which have come to be regarded as Specialism. Now we fear that this word Specialism rings harshly on the ear of a large majority of our fellow-students, and to account for this we have only to look to the traditions and teachings of which we have spoken above. Few of us can have gone the rounds of the wards for long together without hearing something to the disadvantage of special hospitals, suggested either by alleged malpractices upon the person of the patient in question at the time, or by the startling diagnosis of which the patient declares his disease to have been the subject. True to our traditions we have invariably accepted—nay, sometimes applauded—the statements with respect to such cases which our teachers have

* See Guy's Hospital Report, 1878, p. 59.

thought fit to make, and so many of us have come to regard the Specialist as an enthusiast (if not a charlatan), who in his zeal for his pet subject has thrown to the winds all his previous knowledge of medicine on every subject except one, and whose treatment is purely local; who, if he be a surgeon, is for ever devising some new and ingenious modification of some familiar surgical instrument; or, if he be a physician, is for ever appealing, in conjunction with this or that noble earl, for support for the institution which provides him at the same time a field of action and an advertisement. Now upon analysing this conclusion we are bound to confess that our righteous indignation has in reality been poured forth upon a few only of the Specialists and special hospitals, and that the sins of the few have sufficed to condemn the many. Let us then, good Guy's men though we be, take a look at the subject from an unbiassed point of view, and see whether after all we may not have something yet to learn from Specialists.

Take, first, diseases of the eye and ear, and in these departments of Specialism we need not to pass our own gates; the few who really enter into the subject there taught cannot fail to be struck by the vast number of morbid conditions, fully recognised and adequately treated, which, though often associated with the constitutional disease, are so often passed over without comment in the general routine practice of medicine and surgery. Apart from the skill and confidence which is gained by the repeated use of the different instruments employed for investigation, we cannot lay too much stress on the evil that may ensue upon the false diagnosis of such affections as glaucoma or optic neuritis, owing to imperfect acquaintance with morbid appearances. Verily, in these matters "a little knowledge is a dangerous thing;" but it is only by systematic study, under special teaching, that we may hope to avoid it.

Another branch of Specialism, little in favour amongst us, is that relating to diseases of the throat and larynx, and we are bound to consider it a matter of regret that no classes for special instruction in this subject, or in the use of the laryngoscope, are held in this hospital. As in the case of the eye and the ear, however, those who will steadily devote sufficient time to the study of laryngoscopy, and the diseases which may be recognised by its aid, will in their turn readily confess that a hasty view of a paralysed vocal cord or an ulcerated epiglottis is not the *summum bonum* that they can arrive at, and that numerous affections, which hitherto they have looked upon as unimportant, or have, indeed, disregarded altogether, will come to have an important place in the diagnosis and treatment of diseases which they have never before considered to bear any relation to them.

That these remarks are not exaggerated, we venture to think that few will deny, and if applicable to the branches of Specialism upon which we have touched, why not to numerous others that might be considered? The general medical and surgical practice of such a hospital as ours offers endless opportunities for the study of the relation of affections of special organs to general disease, but that study must of necessity be imperfect unless founded upon a true knowledge of the special affections of such organs, independent of such general disease, and it is only by intelligent study of these affections that we can hope to make our diagnosis of value to ourselves or our professional brethren, or our treatment give relief to our patients.

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GUY'S HOSPITAL GAZETTE,

OCTOBER, 1878.

CASE OF ENTERITIS AND TUBERCULAR PERITONITIS.

With Remarks by Dr. Goodhart.

(*Continued from page* 101.)

Then another large group is formed by selecting those cases which exhibited symptoms of blood-poisoning (eight out of eighteen were thus associated), and it is quite possible that three others should also be added, including our present case, for these very acute cases are at least as likely to be dependent upon blood-poisoning as that the enteritis is the primary disease, and the constitutional symptoms secondary, seeing that there is no suggestion of any cause for the enteritis. Thus in cases of pyæmia, which show no definite cause, it may be well to think of enteritis. A third group was associated with renal diseases, and they are important, not only as a group of cases indicating a general cause, but as suggesting perhaps, a local origin. It is very seldom that patients suffering from Bright's disease are not freely purged, and you will remember, on a previous occasion, I gave you instances in other parts of the tendency of local inflammation to become aggravated in Bright's disease, and to assume a suppurative or sloughy form.

The other cases were one after hernia and purging, a cause so obviously sufficient to produce the effect that I need say no more about it, and one with cirrhosis, and one with cancer of the viscera. Now I do not know in these two cases what was the actual cause of the disease, but I think it likely that they represent an important group of cases which still requires further elucidation. Let me illustrate this by a reference to two other cases:—Some time ago my colleague, Dr. Hilton Fagge, was called down to Blackheath, with Dr. Finch, to see a lady, aged 34, who had that morning been seized with abdominal pain and collapse. She had been confined five weeks before, and phlegmasia dolens had followed. She had also had some troublesome diarrhœa. At six a.m. she was suddenly seized with violent abdominal pain and vomiting, and complete collapse, from which she never rallied, and died in eleven hours. The post-mortem showed the intestine to be of a purple black colour from below the duodenum to the middle of the small intestine, and this was due to thrombosis of the superior mesenteric and portal veins. Thus the case was cleared up. There had been phlegmasia dolens with thrombosis of various veins—the portal among the number—and the thrombosis had led to a state of intestine bordering upon gangrene. The other case was that of a woman, aged 49, whom I was asked by Mr. Howse to see in the early part of this year in Dorcas. She was a married woman with a family, and had had good health till eight months before, when she had abdominal pain and vomiting. These attacks recurred occasionally, and she was admitted with gangrene of the leg and uncontrollable diarrhœa. She was extremely wasted, and eventually died. The diagnosis I made was one of chronic ulceration of the colon, and so far I was right; but there was extensive ulceration and ecchymosis of the small intestine also, and this was associated with thrombosis of the superior mesenteric artery. I have seen another case—one of umbilical hernia—where ecchymosis and ulceration of the colon went with thrombosis in the corresponding mesenteric veins.

Now we know from experience in hernia that as long as there is no strangulation, as it is called, the symptoms may show but little urgency; but so soon as the circulation becomes arrested in ever so small a piece of bowel then severe symptoms follow at once. It seems highly probable that this holds good for a class of cases I mentioned last lecture, viz., cases of volvulus. The severity of the symptoms is in such very great, the collapse is sudden, and death very rapid, and by these points it can be distinguished from many other varieties of intestinal obstruction; while after death the implicated intestine has been found in such a congested state as to prove some very serious disturbance in the circulation of the part. It is, perhaps, not very easy to say why death should be so speedy in cases of arrest of the circulation in a part of the intestine; that it is so is certain. It seems, too, not unlikely that what is true for strangulated hernia, volvulus, &c., may also be true for some of these severe forms of enteritis, and that we shall find in future that some of them also are due to some sudden stoppage of the circulation in the mysentery by thrombosis or otherwise. If we can assume such a condition, and start with them from other cases, we have ground for supposing that from it a severe form of enteritis or gangrene may be set up, and severe symptoms are likely to follow. The two cases of enteritis with cirrhosis and cancer of the viscera respectively seem to me likely cases for the occurrence of some such mesenteric stagnation, and though there is no account of anything of the kind, it seems a point so very liable to be overlooked that, failing any other cause, I think that possible.

Thus, then, I am inclined to consider phlegmonous enteritis as due to various causes. In some cases it is the local manifestation of a general blood disease, just in the same way as the lesions of Peyer's patches or those of the fauces are indicative of the typhoid or diphtheritic state or poison. In some it is an intestinal cellulitis or lymphangeitis dependent upon local irritation and an unhealthy constitutional state combined; in others it may be brought about purely by severe local irritation, or it may be a local disease dependent upon some interference with the circulation

by thrombosis or embolism of either the supplying or draining vessels. This scheme will not help you much, but it will bring the disease to your notice, and will suggest to you some of the possible causes of it, which, if you bear them in mind, may occasionally throw light upon cases of some obscurity.

But even with all your pains there are some cases in which it will be impossible to decide as to the cause of the disease, and the case I first read to you is one of them. Here is a man, apparently in health, struck down and dead within a few days with a severe inflammation of his intestine, and what it was due to I do not know. The first thought that struck me was that it was some severe blood-poisoning, and I recalled to mind a plate of somewhat similar appearances that I had seen of the stages of disease in the intestine in animals affected with cattle plague, and that hypothesis still remains as probable, but there is no evidence in its favour. Bad drains and bad water are supposed to explain many of the low and desperate forms of fever. So I went to the address the man gave to see if haply his disease could be explained by his habitat. But no. He came from a common lodging-house, it is true, in a court in the Borough, but all appeared to be in an exceedingly cleanly state, and nothing to find fault with in closets or water. Moreover, there had been no other illness in the house. Then I handed the viscera over to Dr. Stevenson to see if he thought there was any probability of some irritant poison causing the inflammation; and I was particularly careful to do this, remembering that some poisons have special affinities for certain parts of the intestine and leave others; arsenic notably acting in this way. But Dr. Stevenson returned them with this note:—

"June 8, 1878.

"DEAR GOODHART,—I have to-day looked at the viscera. I think that, on the whole, the appearances are against irritant poisoning, for—

"(1.) It is not clear that the stomach is affected as well as the intestinal canal;

"(2.) The inflamed patches are widely distant in some parts;

"(3.) The intervening portions of intestinal canal are free from inflammation.

"The stomach was green and much decomposed; it did not, however, exhibit the same appearances as were met with in the intestines, large and small. As a rule, inflamed intestines without inflamed stomach is *not* poison. This rule is a pretty safe one.

"The case is a very interesting one.

"Very truly yours,

"THOS. STEVENSON."

"Dr. Goodhart."

There the case stands, partly elucidated by a reference to somewhat similar cases, but by no means entirely cleared up, and still supplying food for reflection.

And now, in the few remaining minutes that are left me, I wish to draw your attention to another puzzling abdominal case that has interested us much during the last four weeks, and the boy having died, the parts have been kept to show you.

Henry May, æt. 15, an errand boy in a hatter's shop. He does not know anything of his family, having been brought up in Hanwell Industrial School till two years ago, when he was taken away by an uncle. He cannot remember having had any illness whatever till his present attack, excepting a severe headache four months ago, when he kept to his bed for three days. Eleven days before his admission he says that he was in perfect health as usual, and took a rather long walk. This was on a Saturday. Next morning he was as well as usual and ate his breakfast, composed of bread and butter and tea. About two hours afterwards he was seized with sudden intense abdominal pain, which doubled him up. He did not vomit. He immediately went to bed, and in the afternoon his stomach began to swell and he had diarrhœa. On the Monday morning, feeling better, he got up and did some work, but was again taken with abdominal pain and compelled to go to bed again. He has since then remained in bed with fever, anorexia, and diarrhœa. The bowels have acted three or four times a day; he has passed no blood. The abdomen became more swollen a week ago, and he has had medical attendance during that time.

With special reference to his earlier history he relates that he had had no diarrhœa, had suffered from no cough, spitting of blood, sweating, wasting, or weakness.

He looked ill, and walked in a semi-erect posture, though after getting into bed his cheeks became flushed. He complained greatly of headache and thirst. He was spare; sordes on his lips; the tongue moist, with a white fur on its dorsum; the abdomen was much distended, the umbilicus parted outwards. Dull in percussion, except in the umbilical, epigastric, and left hypochondriac region. There is some slight thrill on percussion, some abdominal tenderness on pressure, not localised. The liver and spleen cannot be distinguished on account of the distension.

The thoracic organs were somewhat displaced by the abdominal distension, the heart beating in the fourth space, and the liver dulness extending to the fourth rib on the right side. There was no marked evidence of any chest mischief. The respiration on the left side was harsh and loud; the expiratory sound at the right apex was bronchial. There was no eruption. Urine, 10·32 normal.

M. T., 103·6; P., 100; R. 30.
E. T., 102·0; P., 88; R. 24.

He was ordered five grains of Dover's powder and milk for diet.

Now the boy had evidently got peritonitis; the question was, what was it due to? The onset was

sudden, so the boy stated very positively, and judging from that we should have inclined to some inflammation of the cœcal appendix—or perityphlitis; some latent typhoid with peritonitis extending through or actual perforation, or some gastric ulcer perforating. I have put them in their more likely order of frequency. But perityphlitis nearly always displays some local induration or swelling in the cœcal region, here there was none; therefore I could not bring myself to think it was cœcal appendix ulceration.

The perforation of typhoid fever is usually very acute when the disease has remained latent, but this boy had been getting along somehow for ten days, and walked up to the hospital after the supposed perforation, so I did not think it typhoid; and as for gastric ulcer, the same argument would hold good for it, and this further one, that gastric ulcer is very unlikely in a boy of fifteen years. Then there was another point about the case, and that was that I felt fluctuation in the abdomen. Now though I do not know why you should not occasionally have fluid in the abdominal cavity in the above-mentioned cases, if we allow that they may occasionally be more chronic than usual; still, I have never seen fluid present either in perityphlitis or other forms of intestinal perforation, and it is certainly extremely rare to find it. So I discarded all three, and having done that, there was only idiopathic peritonitis and tubercular peritonitis to fall back upon. The former, perhaps, occurs in children occasionally, and may be associated with ascites; but is rare in any one at adult age or approaching it, and I therefore considered the case one of tubercular peritonitis. At the same time it was a very unusual history. Such a sudden onset; for tubercular peritonitis is in general rather insidious in its first appearance, though afterwards fluid may form very rapidly, and the case ran its course in six or eight weeks. Well, after his admission the first thing that was noticed was that his temperature was high, and that he had profuse diarrhœa, with liquid yellow stools, and these symptoms were as consistent with typhoid fever as with tubercular disease; the diarrhœa was, on the whole, inconsistent with cœcitis. But with regard to the character of the motions, I said then and say now, as important to remember for accuracy in diagnosis, that if the intestine is acting hurriedly for any length of time, you will probably have ochre yellow stools like those of typhoid fever, and it is doubtful whether typhoid stools have any other significance than excessive and continuous intestinal action by which the liquid bile-coloured contents in the upper part are passed onwards.

But then came another phenomena in the case which puzzled me, and that was that within a day or two of the boy's admission the evidence of fluid in the abdomen disappeared. The abdomen remained as full as ever and as tender, but it became tympanitic and there was no longer any fluid. Tubercular peritonitis probably gets well occasionally, so that it would not have surprised me at all to see the fluid grow less in quantity after some time, though the probabilities would favour its increase rather than diminution, but to find it all go within three or four days was certainly a very remarkable incident, and then I began to be a little uncertain in my diagnosis. Thinking it unlikely that the fluid could be absorbed so quickly, I began to doubt—only that Mr. Poland would not let me—whether we had not made a mistake, and whether the tumid abdomen had not given a thrill which we had mistaken as fluid. That is a mistake only too easy to make sometimes, and if you confine yourself to mere lateral vibrations. But to suppose a mistake in this way was to shake one's faith in the correctness of the diagnosis of tubercular peritonitis, for the fluid was the one point which gave decided indications. The case was treated by opium to curtail the diarrhœa and ease the pain, which was at times very severe, and, thinking it tubercular, some mercurial ointment with belladonna and glycerine was applied to the abdomen. I think I have seen a good deal of benefit in some cases from the application of mercurial to the abdomen in tubercular peritonitis, and should advise you to try it. It brought out a very copious crop of pustules in this case, and we had to stop it very soon, and henceforward kept to opium. The diarrhœa was very persistent, four or five limpid motions a day, and towards the end vomiting was superadded. The latter was so obstinate that had he not had diarrhœa also some obstruction might have been suspected. It was to a certain extent controlled by reducing the nourishment taken by the mouth to a minimum, and feeding him by enemata of raw meat and milk. It was due, one must suppose, to the extent of peritoneal disease that existed, though I hope that it was merely the persistence of a habit induced by the peritonitis, and which we might have overcome by time and careful feeding. With regard to the bearing of this symptom on the diagnosis of typhoid fever or not, I should say that vomiting is sometimes noticed early in typhoid, when it is a symptom rarely obstinate or important; sometimes after the twelfth day, when it usually indicates peritonitis. I thought, too, that it might be dependent in this case upon the distended abdomen, which might, I thought, be due to some atonic state of bowel if the typhoid hypothesis was correct.

Once or twice I thought he seemed to be going to pull through, though the abdomen never lost much of its rounded tympanitic state, and he gradually emaciated to an extreme degree. He ultimately died off somewhat suddenly. At the post-mortem we found the intestine and peritoneum adherent in all directions by means of a closely set layer of large caseous yellow tubercle, and, with the exception of some caseous mediastinal glands, no other disease was found. In this respect the case was a little uncommon. I usually teach that tubercular disease of the peritoneum is of two kinds, that associated with caseous mesenteric glands or tabes mesenterica, in

which case the disease is more chronic, and thought he abdomen is full, occasionally, perhaps, lumpy, there is often not much fluid; and that form in which the peritoneum is loaded into grey tubercles, in which ascitic fluid is present in abundance, and the course of the disease rapid (six or eight weeks); but there is another occasional variety, in which the peritoneum is pasted all over with a thick layer of caseous matter, sometimes reaching a centimeter in thickness in some parts. This variety is unassociated with fluid. You will see by an examination of the parts upon the table that the post-mortem has confirmed the original diagnosis of tubercular peritonitis, and of a kind intermediate between these last two, and a form which I do not think could be expected to recover when it had proceeded to such an extent as it had done.

CASE OF COMPOUND DEPRESSED FRACTURE OF SKULL. TREPHINED.

UNDER THE CARE OF MR. JACOBSON.

G. S., æt. 11; admitted August 13th. Patient was playing on the railway when an engine came suddenly up, and striking him on the head knocked him down, the wheels passing over his right arm below the elbow.

On admission into Cornelius Ward there was found to be a compound comminuted fracture over right parietal bone, a square bit of bone driven in beneath the surrounding bones, some separation of right parietœ frontal suture, right eye much bruised, discoloured, and closed; laceration at outer side. Patient was continually muttering; when roused spoke incoherently; could move all his limbs. His right arm was almost severed below the elbow, greatly crushed; tendons, muscles, and bones mangled in an almost indistinguishable mass, the thumb and forefinger alone escaping. Continuous hæmorrhage; pulse steady and running.

$CHCl_3$ administered, trephine applied, and four pieces of bone removed, leaving a cavity measuring about $1\frac{1}{2}$ by $1\frac{1}{2}$ inches. Dura mater was found uninjured. The whole operation carried out under the spray. Right arm was then amputated above the elbow.

Patient was then put to bed; ice-bag to head and hot water-bottles to feet.

5.45 p.m.—T., 99·6.

9.30 p.m.—T., 100; P., 160, small and running. Restless, moves constantly both legs, is conscious and sensible, calls for water, occasionally dozes heavily; has given his name.

August 14th, 5.30 p.m.—Dressed, no hæmorrhage, wound over orbit almost closed. Patient calls out when hurt, is partly sensible, dozing at intervals, then becomes restless, plucking at his bedclothes, drawing up and then kicking down with his feet.

9.15 p.m.—Quiet from 5.30 till 9, then became restless, tossing his limbs about. Hyd. with Cretœ. gr. iij. administered; has been quiet since. Bowels not open, has passed clear urine twice, spoke sensibly when roused.

1.0 a.m.—Hyd. with Cret. with Dover's powder given.

August 15th.—Slept quite quietly after 1.0 a.m. this morning. Hyd. with Cretæ. gr. iij. with Pulv. Doverii gr. i. administered every two or three hours.

9.15 p.m.—Has taken about five ounces of milk to-day, and remains quietly sleeping for the greater part of his time, quite sensible when roused.

August 16th.—Head dressed to-day, no pus or smell. T., normal; P., 100. Feels very hungry; bowels opened.

August 17th.—Arm dressed and drainage tube taken out. The greater part of the flaps have united. Bruising about right eye is disappearing, can now see out of it. P., 92; T., normal.

August 20th—Dressed to-day; does not complain of any pain. Wound over skull is granulating, small piece of bare bone with granulations spreading over it.

August 21st.—Dressed again this morning.

August 23rd.—Arm has quite healed up, sutures taken out.

August 31st.—Up to this date patient has been kept on a milk diet and bread and butter. To day he has had chicken.

September 3rd.—Sits up in bed. Wound of skull almost closed up; small patch of granulation, about the size of half-a-crown.

September 7th.—Allowed to get about ward to day. Meat diet.

September 17th.—Is still progressing satisfactorily.

August 27th.—Up to this time patient has continued walking about the ward and colonnade all day. Arm remains perfectly healed; wound over skull is almost completely closed. There is a very small strip of granulation, which is dressed with Boracic lint. Is soon going out of hospital.

CASE OF PSOAS ABSCESS.—CURED BY HYPERDISTENSION, WITH CARBOLIC LOTION.

G. W. J., æt. 9. Admitted August 9th.

Family History.—Good.

Personal History.—Has been very delicate from birth. When two years old slight angular curvature of spine was noticed. This increased, and he became an in-patient at the Evelina Hospital for some time. About six months ago a swelling was noticed at inner side of right thigh, directly beneath Poupart's ligament. This went on steadily increasing until admission.

On Admission.—Patient is a small, pale, sickly-looking boy; has angular curvature in dorsal region.

No pain on pressure over spine. On inner side of right thigh, and a little anterior, there is a rounded fluctuating swelling about the size of an orange.

August 10th.—Abscess showing signs of bursting. $CHCl_3$ was administered, and the abscess was opened under the spray. About seven ounces of thin pus with flakes of lymph and several small pieces of cancellous tissue came away. Eight ounces of carbolic lotion, strength 1 in 20, were injected into the cavity and allowed to remain for some minutes, then allowed to drain away slowly; drainage tube put in and gauze over all.

August 11th.—Dressed; some more lymph and cancellous tissue, with small quantity of pus.

September 2nd.—Has been dressed every other day. There is now no discharge. Lotion injected comes away quite clean. Drainage tube taken out.

September 6th.—Opening in abscess has healed.

September 13th.—Patient was suspended to-day and Sayre's splints put on.

September 25th.—Patient has been allowed to walk about since the application of the splint, and to-day went out of hospital.

ALFRED G. WELLS.

GUY'S HOSPITAL PUPILS' PHYSICAL SOCIETY.

Session 1878-9.

Honorary President:
Dr. Wilks.

Presidents:

Mr. H. Davy.	Mr. G. H. Russell.
Mr. W. D. Hartley.	Mr. A. Scott.
Mr. P. Horrocks, M.B.	Mr. C. T. K. Shaw.
Mr. W. Lane.	Mr. T. S. Sheldon.
Mr. G. Mackern.	Mr. J. C. Uhthoff.
Mr. A. E. Maylard.	Mr. R. S. Wainewright.
Mr. J. T. J. Morrison.	Mr. W. H. White.
Mr. J. Poland.	Mr. G. A. Wright, M.B.
Mr. B. N. Rake.	Mr. L. C. Wooldridge, B.Sc.

Meetings at half-past Seven o'clock.

R. Clement Lucas, B.S. } *Hon. Secs.*
C. J. Symonds, M.B. }

We have much pleasure in offering to our readers the subjoined list of the names of those gentlemen who, during the coming winter session, will read papers at the Physical.

It will be noticed that many have not yet given in the subject of their essay. We do not think, when it is well considered, that this is at all a matter for regret; for though the subject of the paper ought undoubtedly to be annonnced at least a week before the night on which it is to be read, yet those who have not given in their subjects will not feel fettered in the least, and so be enabled to choose any subject which may be palatable to them, or with which, from the circumstances surrounding them, they find themselves best acquainted.

Hence, though at first sight the list looks incomplete, we hope that the result will be papers more practical, and more profusely embellished by clinical work.

And here we would suggest to those about to write their essays that, although they can, undoubtedly, by collecting all the literature of their subject, and picking out bits here and there, compile an essay, "two lines of which may utterly confound their hearers," and inspire them with a due appreciation of the profundity of the knowledge of the essayist, yet, by reading up their subject from books as extensively as they may be able, and backing this up with work in the wards, finally sitting down and writing a composition "out of their heads," if we may be allowed the expression, in their own language, they will certainly derive more benefit themselves, will be better understood by their hearers, and will give more satisfaction to the Physical Society.

The Presidents of the society every year invite all first year's men, whether members or not, to the first meeting, in order that they may see and hear for themselves, after which there will probably be no hesitation about becoming a member. Now we strongly advise all who can to accept this invitation, and have no doubt they will be entertained and instructed. If they turn back the pages of Guy's history they will find the majority of those who have become distinguished were also distinguished members of the Physical. We do not mean to assert that to get on, or to have a brilliant career, it is a *sine quâ non* to belong to the Physical Society, but one thing is quite certain, that to be so materially aids a student in many ways. For instance, it is one of the very best means of eliminating that nervous trepidation which most men experience when first they rise to speak before an assembly; by practice in speaking they become quite courageous, and thus are able after a time to discourse fluently, the whole of their mind being occupied with the subject in hand without the disturbing element of fear. Again, they will hear papers on medical and surgical subjects, and discussions following, in which opinions are given and quoted, so that on leaving a Society's meeting a student finds himself possessed of a fair knowledge of the subject treated, which has been acquired in a very pleasant way, having, in fact, flowed passively into his soul without any active putting forth of energy. But we need not go into the matter further. Those who stay away, despite all solicitations, may happily never know the grand opportunities they have neglected, whilst those who go will never regret.

We are glad the first night is on "Acute Rheumatism and Salicylic Acid," for no doubt it will elicit a good discussion, in addition to which it will be intelligible to the first year's men.

1878.—Saturday, October 5th, Mr. C. H. Downes.—"Acute Rheumatism and Salicylic Acid."
Saturday, October 19th, Mr. R. Parry.
Saturday, November 2nd, Mr. T. W. Fuller.—"Gastrostomy."
Saturday, November 16th, Mr. H. E. B. Flanagan.—"Phthisis."
Saturday, November 30th, Mr. O. B. Shelswell.
Saturday, December 14th, Mr. H. Sturge.—"Notes on Skin Diseases."
1879.—Saturday, January 11th, Mr. E. Penny.
Saturday, January 25th, Mr. G. J. Wilson.
Saturday, February 8th, Mr. T. H. Morse.
Saturday, February 22nd, Mr. W. Whitworth.—"Diarrhœa."
Saturday, March 8th, Mr. F. T. Bayes.—"Nitrogenous Metabolism."
Saturday, March 22nd, Mr. J. Cock.

Death.—August 16th, on the voyage out to Calcutta, William Wyatt Pinching, M.R.C.S., L.R.C.P.

GUY'S HOSPITAL GAZETTE,

OCTOBER, 1878.

FROM time to time articles on Medical Education have appeared in the *Gazette*; during the last year especially, prominent attention has been paid to this very important part of a medical man's life. But all this has been chiefly meant for those who are more or less cognisant of the duties lying before them, and we trust the hints have been useful. In this article we mean more especially to address those who have chosen Guy's as their *Alma Mater*, and who enter as First Year's Men this Session. We give them a hearty welcome, and congratulate them on their choice of a Hospital.

It is well known, and who has not experienced it? that a feeling of awe attaches itself to the freshman for the first few months, his seniors are magnified to an extent that would make them proud had they not the keen remembrance of having done the same themselves—everything is new to him—a hospital is such a special place, a *terra incognita* to the uninitiated, where new wonders develop every day, consequently the freshman feels his seniors far in front of him in the race for knowledge, and his awe is mixed with reverence. Let this be a hint to the seniors, that they make good use of their position; many an acquaintance struck up in the dissecting-room results in an influence for the rest of the student life, an influence that may be for good or for bad. If the freshman regard his seniors with awe, let us assure him his seniors look at him with a certain amount of interest, there is anxiety to know what the new blood is like, whether it promises good things for Guy's in the future; those who figure with prizes and certificates at the Entrance Examinations are specially watched and criticised, how many are University men? will they do well at the Prelim.-Sci. and first M.B.? As the session goes on other questions with a different purport are asked, and very soon the reputation of a *Year* is won or lost. This battle of the Years is always being fought out; round the fire in the Rooms many a warm discussion as to the relative value of the different years takes place, a brilliant man may gain extra *Kudos* from his year being a bad year; or again, a good man may find it hard work to come into the front rank of the men of his year because it happens to be a good year. We mean this as a hint to the First Year's Men, the reputation of their year depends on *themselves*; once made it is not easily lost, especially with the Staff, *more* especially, we might even say, with the Lecturing Staff. The "Bob Sawyer" and the "Hat smashing" periods have both undergone the wholesome process of evolution let us hope.

To a man who has really chosen his profession his work soon brings a vast amount of interest. We will suppose he has begun his hospital career having previously acquired, what is so essential now, a knowledge of chemistry and physics; scarcely has he finished his first chapter in Kirkes' or Foster before he finds out he must remember his Chemistry, and his lecturer on Physiology also takes care to remind him of the same thing very soon, and long before he has found out the drudgery of learning his bones, he sees in what good stead his knowledge of Mechanics will stand him in studying Anatomy. If he also has a knowledge of Comparative Anatomy so much the better will he understand the complex organism of Homo; the embryonic structure resembling the noto-chord found in the Ascidians, and the quasi cranial cartilage covering over the coalesced cephalic ganglia in some of the cephalopoda will have greater significance when he comes to study the highest of the Vertebrata. He who wishes to learn his profession as it deserves to be learnt will not listen to those who, having just scraped through the Preliminary "Hall" or "College," express great scorn for "Science," their chief argument being, as is well said in the last number of the *Gazette*, that their respectable practitioner fathers never studied science and yet have got on well. It never occurs to them that they might have done better; the real reason is that they do not know any themselves, and theirs is the loss, for they must lack an intelligent idea of a great part of physiology, and that is a great loss by itself alone. We do not wish to make too much of this, but this influence of students on students is very evident and recognised. We earnestly recommend men—and there are plenty of them, who do not know exactly what to do—to consult

the Demonstrators and other members of the Staff, who are always only too willing to help on a man who wants to make the best use of his time; and this leads us to consider more in detail the facilities for learning elementary work at Guy's.

In the first place is our large Dissecting-room usually well supplied with subjects, and the magnificent and unique collection of Anatomical wax models in the Comparative Anatomy Museum; the latter are immense helps to the study of anatomy, but not intended in any way to replace the actual process of dissection, which is so essential. Osteology, also, may be well learnt, and bones to study obtained in the museum. Added to all these are the demonstrations and special classes held by the demonstrators; the higher standards of examinations have led to more complete class teaching than formerly. Even six or seven years ago demonstrations were only given now and then, and there were no such things as special classes every year before the first college; every possible help, then, is given to men preparing for that ordeal.

The teaching of physiology also has undergone improvement, the practical study of histology being of comparatively recent date; now *every* man has the opportunity of actually preparing and seeing for himself the normal tissues of the body.

Lectures on chemistry, illustrated by experiments, are delivered all through the winter, and practical chemistry in the laboratory goes on during the summer. Lectures on botany, with a practical course in histology also go on during the summer.

The first-year's man, in glancing through this sketch, may look forward to spending his first year in a very pleasant way. It used to be said that more sowing of wild oats went on during the first year than anything else, but now with stiffer examinations and with increase of knowledge there is no time for that expensive process.

Taking into consideration, then, the increased and improved facilities for teaching, the increase of 25 per cent. in the fees is not to be wondered at. This question was fully discussed in the *Gazette* a few months back, and the conclusion arrived at was that if a man is to be better educated now he must be ready to pay for it. It would be well if the many fathers and guardians who come up with their sons, &c., during the first week in October would take a turn round Guy's as it is, and compare it with what it was when they were students, especially the medical school department.

The Physical Society still continues its flourishing condition, and, as Dr. Wilks remarked two years ago, it becomes the duty of every man who comes to Guy's to join this most ancient of medical societies.

An innovation of late years is the *Guy's Hospital Gazette*, published monthly, and conducted by students —the presidents of the Physical Society—and every man is expected to subscribe to this, the only Hospital Gazette in London.

Having thus briefly sketched out the immediate future of the tyro in medicine, it is unnecessary for us to surround with a halo of glory his chosen profession, according to the method of those who deliver opening addresses; we feel assured that the intense interest of the work itself will in time beget a corresponding enthusiasm in the student of a profession the aim and object of which is to alleviate human suffering.

MEDICAL DEGREES.—PARIS.

It will be best to preface an account of the course of study required in this town for obtaining the title of Doctor of Medicine (M.D.) by a few general remarks upon the School of Medicine (Ecole de Medecine) and hospitals in that place.

Paris and Montpellier are the two French faculties or superior schools of medicine, either of which can confer degrees enabling the recipients to practise in any part of France, but the system of medical instruction carried on in those towns differs essentially in many particulars from that observed in England. In Paris medical students, instead of belonging to one of the hospitals, are all attached to the School of Medicine (Ecole de Medecine), from which their diploma is finally to be obtained. It is there that the lectures are delivered and the examinations passed; it is there settled to which hospital each student shall be attached; and the clinical instruction carried on at the hospitals is there regulated. The hospitals are visited at 8 a.m., and the clinical lectures (the only ones there delivered) given in the morning, so that after 10 or 11 a.m. the student is at liberty to attend the lectures at the Ecole de Medicine, dissect, or devote his time to that branch of medicine in which he may be specially interested. The lectures delivered daily at the Ecole are upon chemistry and natural philosophy, botany and zoology, anatomy and physiology, medicine and surgery, midwifery and gynæcology, materia medica and therapeutics, medical jurisprudence, histology, &c., in fact, upon every subject connected with medicine, and being delivered by professors specially appointed by the government for this purpose, are excellent

in all respects. They are not compulsory, but gratuitous; nor is any payment made for hospital attendance. The examinations are almost entirely vivâ voce, and, as might be expected, are conducted in the French language.

Before commencing to study medicine in Paris it is necessary to be inscribed at the School of Medicine (Ecole de Medecine), and this is only possible when two examinations, which may be looked upon as corresponding to the matriculation examinations at the universities of this country, have been passed at the College de la Sorbonne. One of these is termed the Baccalaureat es Lettres (Bachelorship in Literature), and embraces literature, history, geography, &c., the other, Baccalaureat es Sciences (Bachelorship in Science), upon natural history, chemistry, natural philosophy, &c. The fee for each examination is 50 francs (£2).

On account partly of the small cost at which a good medical education can be obtained, and partly of the facilities for the study of many branches of medicine which are offered in Paris, this school is largely resorted to by students from other countries. Certificates of medical studies in a foreign faculty are considered as equivalent to certain of the examinations to be passed, and by application to the Rector of the Sorbonne (Recteur de la Sorbonne), and Minister of Public Instruction (Ministre de l'Instruction Publique), some of the examinations, viz., the Baccalaureats, and, perhaps, the Examens de Fin d'Dannée, may be dispensed with.*

Supposing, however, that this is not the case, and that the whole course of study has to be gone through, when the two Baccalaureats above mentioned have been passed at the Sorbonne, the student may enter his name at the School of Medicine, where he obtains a carte d'inscriptions to be explained, and his medical studies commence. The scholar year begins in Paris on the first day of November, and not as in England, upon the same day in October; and during the first four years of study the medical student is required to present himself once in every three months, on specified days, at the Ecole de Medicine, to pay the sum of 30 francs (25/-), and take one of the sixteen inscriptions required. This term is applied to his atttendance being registered on the carte d'inscriptions above mentioned, which is a paper having the student's name marked upon it, and with sixteen divisions, one of which is filled up on each occasion.

At the end of the first scholar year, viz., in the following summer, the first examination at the School of Medicine has to be passed, being in Natural Philosophy, Chemistry, and Natural History; the latter including Zoology and Botany. This is termed the first examination of the end of the year (le premier examen de fin d'année), and it is not until this has been passed that the fifth inscription can be taken. The fee for this examination, as for all the examens de fin d'année, is 30 francs (25/-).

During this year the time is partly employed in dissection, which is carried on in a building called the Ecole Pratique d'Anatomie (Practical School of Anatomy), a kind of supplementary school, situated opposite the Ecole de Medecine in the same street (Rue de l'Ecole de Medecine). Twenty francs (16/-) is the sum charged for the privilege and opportunity of dissecting during the year. Dissection may again be carried on at Clamart, which is also on the south side of the Seine, and near the Jardin des Plantes, where a school exists for this purpose.

At the end, viz., in the summer of the second year, during which the four next inscriptions have been taken in the same way as in the previous year, the second examination of the end of the year (deuxième examen de fin d'année) must be passed, being in anatomy and physiology, and it is not until this has been done that the ninth inscription can be taken at the commencement of the following year.

During the third and fourth year, in which the eight last inscriptions are taken, hospital attendance is required; but this bears no resemblance to the clinical work in this country on account of the different manner in which the hospitals are supported. Instead of being maintained, as in England, by endowment or private charity, the expenses are paid by the government, and the Ecole de Medecine is thus entitled to attach students to any hospital in the town. A student may attend the hospital—

1. As stagiaire (attending terms), in which character he probably commences his hospital attendance, accompanying the physician or surgeon during his visit to the ward. He also performs some of the more elementary parts of the minor surgery required, viz., making up poultices, applying lotions, ointments, &c.

2. As externe, a name given to an appointment obtained by competitive examination, and as which he takes a more active part in the minor surgery of the ward.

3. As interne, the internes corresponding with the house surgeons and house physicians in this country, and being also elected by competitive examination.

As has been observed, the School of Medicine decides to which hospital each student shall be attached; but he is at liberty to apply there for permission to attend whichever hospital, and whichever physician or surgeon at that hospital, he himself prefers. Since, however, the students mostly reside in a part of Paris termed the Quartier Latin, on the south side of the Seine, the general wish is to be attached to the hospitals in that part of Paris (Hopital de la Charité, Hopital de la Pitié, Hotel Dieu, &c.), and consequently this is only allowed to those who have passed the last examination exceptionally well, while other students have to choose hospitals at a greater distance from their lodgings (Lariboisière, St. Louis, Necker, &c.).

The third scholar year being terminated, an examination has to be passed in medicine (pathologie interne) and surgery (pathologie externe) before the thirteenth inscription can be taken, and during the ensuing year (fourth year, second year of hospital attendance) the four last inscriptions are taken in the same way as in the previous years.

The fourth year being thus ended, the three examens de fin d'année passed, the sixteen inscriptions taken, and the hospital attendance terminated, the five examens de doctorat (examinations for the doctorship) have still to be passed, and a thesis to be written before the diploma is obtained. It is not, however, necessary for a year's interval to elapse between these examinations, and as soon as the subjects are prepared the student may apply at the Ecole de Medecine and obtain thus the opportunity of presenting himself. Of these examinations—the fee for each of which is 90 francs (£3 15s.)—

The first is upon anatomy and physiology, and a part has to be dissected.

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* In this case a letter, such as the following, might be written:—

MONSIEUR LE RECTEUR,

Ayant fait mes etudes litteraires et scientifiques dans le Collége d'Allstudy je suis arrivé à Paris pour me faire inscribe à l'Ecole de Medecine, et pour entreprennre toutes les études necessaires pour obtenir le titre le docteur de cette célèbre facultié; mais pour atteindre mon but je viens vous prier, Monsieur le Recteur, de vouloir bien considerer le titre cünclus comme l'equivalent des Baccalaureats es Lettres, et es Sciences pour que je puisse prendre de suite ma première inscription à l'Ecole de Medecine.

Je suis avec un profond respect, Monsieur le Recteur,

Votre bien devoué serviteur,

A. B.

Should the dispensation be granted, an answer such as follows would be received:—

Le Ministre Secretaire d'Etat au Department de l'Instruction Publique.

Vu les piecès produites par M. A. B.

Vu l'article 5 du decret du 22 Août, 1844.

Arrêté:

Le titre delivrè par le Collége d'Allstudy á M. A. B. (Angleterre), est déclaré l'équivalent aux deux diplômes Francais de Bachelier es Lettres et de Bachelier es Sciences restreint pour l'étude de la medecine.

Fait à Paris le, &c.,

Signé, X. Y.

The second is upon medicine, surgery, and operative surgery.

The third on medical natural history, natural physiology, and pharmacology.

The fourth on hygiene, medical jurisprudence, and therapeutics.

The fifth is a clinical examination at some hospital on medicine, surgery and midwifery, or gynæcology.

In case of rejection at either of these examinations, or of those of the fin d'année, another trial is usually allowed at the end of three, or less often, of six months.

Finally, a thesis has to be written upon some subject connected with medicine or surgery, and selected by the candidate. This is discussed upon a specified day before a president and three examiners, and when these have expressed their approval of its contents, the diploma of Doctor of Medicine (M.D.) may be obtained. The fee for this examination is 100 francs (£4).

En resumé, in obtaining the diploma of M.D. at Paris, the following is done:—

	fcs.	£
1st.—The Baccalaureats es Lettres and es Sciences are passed at the Sorbonne, the fee for each being	50	= 4
2nd.—The five examens de fin d'année are passed at the Ecole de Medecine, the fee for each being	30	= 6
3rd.—Sixteen inscriptions are taken during the four years, the fee for each being	30	= 19
4th.—The five examens de doctorat are passed, occupying at least one year, the fee for each being	90	= 18
5th.—The thesis is discussed and the diploma is obtained, the fee for each being	100	= 8
		£55

Thus the time occupied in obtaining the diploma of M.D. at Paris is at least five years, unless, of course, the examens de fin d'année are dispensed with, in which case this might be done within one year, the examens de doctorat having alone to be passed, and the thesis to be written. The expenses are comparatively small, amounting altogether to little more than £50, as above explained.

MONTAGU LUBBOCK.

TONIC SPASM OF THE TRAPEZIUS MUSCLE.

The following interesting case came to the out-patient's department when I was junior House Physician.

Eliza B., a well nourished, intelligent girl, 10 years old, first came under observation, March 1st, 1878, giving the following history: She had enjoyed good health until twelve months ago, when she began to get thin and lose her appetite. Last May, when at school, she suddenly "felt her neck become stiff, and her head was turned towards the right side." At the same time she complained of a good deal of pain in the cervical region. The spasm was tonic, lasted seven days, and then left her quite suddenly, when she resumed her ordinary health. A second, and perfectly similar attack, came on about a fortnight before Christmas, but this lasted nine days.

The present attack came on five days ago, in the same manner as the two former. On examination, it was found that the head was inclined towards the left side, the occiput drawn backwards towards the left shoulder, the chin being elevated and pointing towards right shoulder; the left shoulder itself being raised, and angle of scapula drawn slightly upwards and inwards.

A vertical line drawn through the centre of the face deviated, at the lower end, toward the right shoulder. The left trapezius was firm and contracted, the free edge being very distinctly felt. The right sterno-mastoid was prominent, but the left could not be seen. Painful points absent. There was hyperæsthesia over the left trapezius, accompanied with considerable pain; the pain disturbing the rest at night. The spasm continues unaltered during sleep. The skin was hot and she had an anxious and troubled expression of countenance. There was some sore throat, tonsils being slightly enlarged, as also were some submaxillary glands in the left side, which the mother stated appeared a few days before the illness commenced.

Any attempt to put the head in a natural position was unsuccessful and caused a good deal of pain. There was no pain induced by sudden pressure on the top of the head. No decayed teeth, no anæsthesia, nor analgesia. The child was not given to excess of emotional feeling, nor had the mother observed any worms.

Examination of the chest revealed no abnormal physical signs. She was ordered some Cinchonine as a tonic.

March 4th.—On the evening of the 2nd she complained of great pain in the left occipital region coming, on in paroxysms. It came on at intervals of about two hours, and was so severe as to cause her to call out. The spasm was not altered during the pain. The hyperæsthesia over trapezius has subsided.

Pot. Bromid. gr. v.
Zinc. Valerian. gr. j.
Aq. Menth. Pip. ʒj t.d.s.

March 6th.—No better. Was very sick after taking medicine; now complains of great headache.

March 8th.—Headache much better, shoulder not so much elevated; sleeps better.

March 11th.—Spasm not lessened, general health improving. On the chance of there being some worms, five grains of santonin were ordered to be administered to the child, followed by a dose of castor oil.

March 13th.—The powder was administered on the evening of the 11th, followed by a dose of castor oil. The bowels were freely opened but no worms discovered. The following day she had frequent micturition, and at night she suffered from incontinence. The urine being of a very yellow colour and staining her linen. She was sick and restless. Next morning the spasm had left her. It seems to have left her suddenly while she was asleep. When she awoke she

was able to move her head freely in all directions without pain,

She was under observation until the end of April, when she went into the country, having no return of the spasm.

Remarks.—Tonic spasm of the trapezius is a comparatively rare affection. It is only cursorily mentioned in the text books. Its etiology is very obscure. It generally arises congenitally or during infancy. Dr. Fagge is disposed to look upon dental irritation or hysteria as probable causes. In the above case neither existed, nor was there any evidence of disease of the cervical vertebræ, a state not unfrequently accompanied by spasm of the muscles supplied by the spinal accessory nerve.

From the description of the position in which the head was placed it will be seen that only the trapezius muscle could have been affected. The diagnosis was confirmed by Dr. Hilton Fagge, and by Dr. Barlow, of the Childrens' Hospital, Great Ormond street.

The case differs from those ordinarily described n being non-persistent, and in the frequency of the recurrence of the attack.

It is much to be regretted that no steps were taken to notice the behaviour of the muscles to electrical stimulus.

The duration of the spasm was too short to allow of any atrophic changes taking place in the antagonistic muscles.

It may be remarked that care should be taken in making a diagnosis, not to confound paralysis of the antagonistic muscle with spasm of the muscle of the opposite side. In paralysis passive movements are always possible.

As a rule the prognosis of spasms is unfavourable, they are generally obstinate and of a very long duration. A favourable prognosis may be given, should the patient be young and healthy, the spasm of recent date, and a source of irritation be found. It is not in any way to be thought that the favourable end to the above case was due to the treatment. The treatment of such cases is most unsatisfactory. Until we can know something of the causation of the spasm, our attempts to relieve it must be purely empirical.

Even electricity is less satisfactorily applied in these forms of cases to the other neuroses.

C. KNOX SHAW.

A REMARKABLE PRESENTATION.

E. M., æt. 30, Union Street, Borough.

Married; seventh confinement; always had good labours before. Thirteen days ago she fell down and struck her side, and has complained of pain ever since. She has felt different while carrying this child to the others. Was called to case about 4 p.m., the membranes had ruptured above 6 a.m.

On examination found os fairly dilated, with something presenting, not unlike placenta, but could find no presentation beyond, no hæmorrhage during the pain, which occurred every fifteen minutes. Junior attended at 5 p.m., but he made no diagnosis, except that it was not placenta prævia, and he thought he could feel an elbow or knee above the mass, posterially and to the left; still no hæmorrhage. Senior arrived at 6.10 p.m.; pains more rapid, blood began now to trickle. He sent for Dr. Galabin. The pain became stronger, and the mass began to move rapidly. At about 7.15 we could see the presentation; pulse kept good up to now, when it got weak, and she began to feel faint. Fœtus born at 7.30, the membranes and placenta coming with a rush. The fœtus was bent, so that the heels touched the occiput, and the presenting part was found to be the liver, and above this the intestines, the abdominal wall being absent; the funis was only two inches long, from the sacrum there grew a large spina befida, the chest was contracted, but the head was normal. Both feet were affected with talipes equinos roser; the point of bone felt above liver was no doubt the right hip. The sex of the monster could not be made out. The fœtus was, of course, dead. The mother made an uninterrupted recovery.

F. E. HUBBARD, Extern.

NOTES ON TOXICOLOGY.

THE MINERAL ACIDS.

1.—SULPHURIC. 2.—NITRIC. 3.—HYDROCHLORIC

The symptoms of poisoning by these acids depend upon the degree of their concentration, rather than upon their quantity; but the following are common to them all: there is an immediate burning sensation in the mouth, followed by violent pain, extending to the stomach, and accompanied by vomiting of dark coloured *coffee ground like* matters, containing blood and portions of the lining membrane of the stomach. All the tract through which these poisons pass is shrivelled and corroded.

Sulphuric acid produces upon the skin a *dark brown or black stain (charring)*, whilst black cloth is stained of a *dirty brown colour*, which afterwards becomes *red*.

Nitric acid turns the skin and woollen clothing of a *bright yellow colour*.

Hydrochloric acid stains the skin *white*.

Treatment of poisoning by the Mineral Acids.

Magnesia, chalk, plaster from an apartment, soap-suds, oil, milk, or mucilaginous drinks, linseed tea, gruel, eggs, and barley water are the appropriate remedies. *The stomach pump should never be employed.*

Post-mortem appearances. These are, corrosions and stains upon all the parts with which the acid has come in contact. The stomach is filled with *black, yellow,* or *brown* fluid, or distended with gas. The vessels of this organ are injected, and its mucous membrane inflamed or charred. Perforation of the stomach is more common in poisoning by Sulphuric than by the other mineral acids. When this event takes place the aperture is irregular, its edges are blackened, and surrounded by intense inflammation, and an indigo blue tint is often observed in the mucous membrane.

SULPHURIC ACID, H_2SO_4. OIL OF VITROL.

Quantity required to destroy life (smallest recorded) one drachm.

Period at which death has taken place (shortest) one hour.

Mode of Extraction from the Stomach.—The contents of the stomach should be filtered, and to the clear liquid any *soluble* salt of barium, *e.g.*, the nitrate ($Ba2NO_3$) or chloride ($BaCl_2$) should be added; a *dense white precipitate* of sulphate of baryta ($Ba SO_4$) is formed; this is insoluble in all acids and alkalies, but may be reduced by charcoal before the blow-pipe, yielding sulphide of barium (BaS), and this with a mineral acid gives up sulphuretted hydrogen (H_2S), which may be known by its communicating a black stain to filtering paper dipped in a solution of lead.

Tests.—For the concentrated sulphuric acid are: (1) Its great weight. (2) Its energetic union with water, giving out great heat. (3) Its charring all organic matters. (4) With metallic copper (Cu) gives off sulphur dioxide (SO_2), known by its odour.

NITRIC ACID, HNO_3. AQUA FORTIS.

Quantity required to destroy life (smallest recorded) two drachms.

Period at which death has taken place (shortest) one hour and three quarters.

Mode of extraction from the stomach.—If administered in such fluids as tea, vinegar, porter, &c., there will be a peculiar smell, in addition to the acid reaction produced by the strong acid. The *orange red* fumes of the higher oxides of nitrogen may *not be evolved* on boiling with copper filings, unless the nitric acid be in considerable quantity; any viscidity in the liquid must be counteracted by dilution with water. Always filter; this operation is almost always very slow, and in its place dialysis may even be resorted to. After filtration the clear acid liquor should be warmed and a weak solution of carbonate of potash (K_2CO_3) added; after concentration by evaporation, paper, dipped into this solution and dried, burns with deflagration. A few drops of the filtered solution on a glass slide, slowly evaporated to dryness, give fluted prisms of nitrate of potash (KNO_3); upon making a solution of these nitrate prisms in water and adding a *green crystal* of the proto-sulphate of iron (Ferrous salt) with a drop or two of strong sulphuric acid, the crystal becomes of a *red brown* colour, due to the formation of the persulphate (Ferric salt).

Tests.—For the concentrated nitric acid are: (1) Stains the skin yellow forming *picric* or *carbazotic* acid. (2) Turns morphia and brucia *red*. (3) In the presence of hydrochloric acid dissolves gold leaf. (4) Gives off *ruddy brown* fumes, with many metals, as copper, mercury, silver. (5) Gives white fumes with the vapours of ammonia. (6) Bleaches a solution of indigo.

HYDROCHLORIC ACID, HCl. MURIATIC ACID. SPIRITS OF SALT.

Quantity required to destroy life (smallest recorded) half an ounce.

Period at which death has taken place (shortest) two hours.

Mode of Extraction from the Stomach.—As a considerable quantity of this acid must be present in the stomach to indicate poisoning (HCl and alkaline chlorides being natural constituents of the fluids of the alimentary canal) all that is necessary is to filter and add nitrate of silver ($AgNO_3$) when a *white precipitate* of chloride of silver (AgCl) will be formed, which is known by the following characters: (*a*) It is soluble in liquor ammoniæ, and reprecipitated by nitric acid. (*b*) It blackens upon exposure to light. (*c*) When heated it melts to a mass called horn silver.

Tests.—For the concentrated Hydrochloric Acid these are: (1) Whitens the skin forming choride of albumen. (2) Dissolves gold leaf in the presence of nitric acid. (3) Gives off chlorine gas when added to dioxide of manganese. (4) Gives white fumes with the vapour of ammonia.

THE VEGETABLE ACIDS.

1.—OXALIC. 2.—CARBOLIC. 3.—PRUSSIC.

OXALIC ACID, $H_2C_2CO_4$

This is an important acid on account of its outward resemblance to Epsom Salts or Sulphate of Magnesia, for which it has often been taken by mistake, and owing to its cheapness and well-known properties, has been frequently made use of to destroy life.

Symptoms of Poisoning.—If a large dose (half an ounce to an ounce) has been taken, there is a hot burning acid taste during the act of swallowing, tightness and pain in the throat, extending to the stomach, great pallor and clammy perspirations, feeble pulse, extreme prostration, intense pain and tenderness over the abdomen, accompanied by vomiting. If the poison be diluted, the vomiting may not come on for a quarter of an hour or twenty minutes; in some cases this symptom has been incessant until death, whilst in others there has been little or no vomiting. It would appear that this acid exercises a remote effect upon the nervous system, since in cases of recovery from the poisonous symptoms, numbness and tingling of the legs have been observed, together with spasmodic twitchings of the muscles of the face and loss of voice, *continuing for a long time.*

Treatment of Poisoning.—Magnesia, plaster from walls, and chalk (carbonate of lime, $CaCO_3$) may be given, this last substance being a direct anedote, since it forms with oxalic acid, an inert substance, viz., Oxalate of lime (CaC_2O_4). Vomiting may be afterwards encouraged by means of sulphate of zinc, in doses of twenty grains, and by tickling the fauces with a feather, &c. *The stomach pump should never be employed.* Alkalies and their carbonates must never be given, since the resulting componnds are as poisonous as the oxalic acid itself. Life has often been desroyed by the *Acid Oxalate* of Potash or or *Salts of Sorrel*, which is sold as *Essential Salts of Lemon*; its poisonous properties depending entirely upon the *Oxalic acid* it contains.

Post-mortem appearances.—The mucous membrance of the mouth, tongue and throat is white, as if bleached, and the stomach contains mucous liquid of a dark brown colour, and almost gelatinous; perforation of the stomach is not very commonly observed, but the organ is often *black* and *gangrenous.*

Quantity required to destroy life (smallest recorded) one drachm.

Period at which death has taken place (variable). Death, in some cases, has occurred very rapidly, but in others has been protracted to the fifth day.

Mode of Extraction from the Stomach.—If the liquid contents be very acid, they may be filtered at once, but if these are not very acid they should be boiled with distilled water before filtration. If the contents be highly coloured, they should be boiled for some time with well-washed animal charcoal, being afterwards filtered, and concentrated by evaporation. They may then be acidulated with Acetic acid and acetate of lead ($Pb2C_2H_3O_2$) added; Oxalate of lead (PbC_2O_4) is thrown down; this may be diffused through water, and into it sulphuretted hydrogen (H_2S) be passed; the lead will be precipitated as the black sulphide (PbS) the oxalic acid being set free.

Tests.—(1) Nitrate of silver ($AgNO_3$) gives a white precipitate of oxalate of silver ($Ag_2C_2O_4$) which is soluble in cold nitric acid, and when heated on thin platinum foil is entirely dissipated in a white vapour, with slight detonation. (2) Sulphate of lime ($Ca SO_4$) gives a white precipitate of oxalate of lime, soluble in the mineral, but not in the vegetable acids.

CARBOLIC ACID, C_6H_5HO, HYDRATE OF PHENYL.

Symptoms of poisoning.—Immediate vertigo and intoxication accompanied by intense burning pain, extending from mouth to stomach, and by occasional vomiting of frothy mucus; the *pupils are invariably contracted*, the pulse is rapid and intermittent, the breathing stertorous, and the breath smelling strongly of the poison. Any urine passed is *dark coloured* and *smoky*, but there is frequently complete suppression of urine;

intense coma may supervene with convulsions. Death may occur rapidly from syncope, or may be prolonged, when it will be probly due to apnœa. The chance of recovery is very slight. Death occurs usually in from thirty minutes to four hours, the shortest recorded period being ten minutes, and the longest sixty hours. Six or seven drops of this acid may cause dangerous symptoms, but the recorded deaths have been generally caused by one, or two ounces, which, of course, is a much greater quantity than is necessary to prove fatal. When used as an injection, or externally applied, fatal results have followed.

Treatment of poisoning.—Emetics of mustard and water and sulphate of zinc and albumen (white of egg) may be employed, and the injection of stimulants to counteract collapse.

Post-mortem appearances.—The œsophagus and mouth are white and corroded, the brain is sometimes congested, fluid being found in the ventricles, which smell strongly of the acid. The stomach is generally white, thickened, and contracted, but sometimes it is intensely congested and the mucous membrane destroyed.

Mode of Extraction from the Stomach.—Unless the odour of carbolic acid can be detected, no tests are likely to be of any avail. For the recovery of the acid, all that is necessary is to mix the organic matters with dilute sulphuric acid, and distil.

Tests.—(1) The *odour* is the most delicate test. (2) It precipitates collodion and albumen. (3) A slip of deal dipped into it and afterwards into hydrochloric acid and then allowed to dry in the air, acquires a *greenish-blue* tint. (4) By mixing the acid with one-fourth of its volume of liquor ammoniæ, and adding a trace of a solution of a hypochlorite, and gently warming the mixture, the liquid assumes a *blue* colour, and if this be acidulated it turns red. (5) Perchloride of iron, when added to the acid, developes a *violet colour*, the intensity of which entirely depends upon the strength of the re-agents employed.

HYDROCYANIC ACID, HCy. PRUSSIC ACID.

Symptoms of poisoning. — These vary according to the amount of the poison taken, a large dose seeming to produce instantaneous death by its "*lightning action.*" If death is not immediate, there will be a hot, bitter taste in the mouth, with increasing giddiness and weakness, severe pain in the head, and gradual confusion of ideas, insensibility and loss of muscular power supervening, the eyes are bright, the face pale and bloated, the breathing becomes *stertorous*, and death may occur from suffocation; the odour of the poison will probably be observed in the breath, the hands may be violently clutched, the eyes glistening and fixed, with wide dilatation of the pupils. A shriek may just precede death, which occurs probably through shock.

Treatment of poisoning.—This may be *general, e.g.*, cold affusions, artificial respiration and the application of ammonia to the nostrils: or *chemical, e.g.*, a mixture of a proto- and a per-sulphate of iron with a caustic alkali may be given internally, forming the inert *ferro-cyanide of potassium*, and should the mixture become acid the inert *Prussian blue* will be formed. Of course, in addition to the above mode of treatment, vomiting may be excited by tickling the fauces with a feather, and using the stomach pump if possible, or by the exhibition of common salt, mustard, and sulphate of zinc.

Post-mortem appearances.—In some cases there have been no morbid appearances at all; frothy foam may be found about the mouth and the *stomach* and *intestines* may be sometimes congested, although they are often quite natural. The *brain* usually presents turgescence of vessels with effusion of serum into the ventricles, the odour of the poison being easily recognised. The *lungs, liver, spleen* and *kidneys* are invariably gorged with blood. The *bile* has often been noticed to be of a deep blue tint, the *arterial system* is empty, but the *venous* is invariably gorged with dark coloured blood. The *blood* may be black or of a cochineal red colour; it is sometimes fluid and sometimes coagulated, and frequently exhales the odour of the poison. These appearances may be observed in whatever way the poison may be administered, whether introduced into the *rectum*, or *vagina*, or applied to *wounds*, or to the *conjunctiva*.

Quantity required to destroy life (smallest recorded), nine-tenths of a grain of the anhydrous acid (= 45 minims of the B. P. acid).

Period at which death has taken place.—This may be instantaneons, but is modified by various circumstances.

Mode of Extraction from the Stomach.—Try to detect the odour. If the contents are alkaline, add dilute sulphuric acid, and place the mixture in a vessel standing in a basin containing warm water at 60° F., and then apply to the rising vapour of HCy the following tests: (1) Moisten a glass slide with nitrate of silver; a *white precipitate* of cyanide of silver (AgCy) will be formed; this is (*a*) soluble in boiling nitric acid, and (*b*) when heated gives off cyanogen gas, which when lighted burns with a rose-coloured flame. (2) Moisten another slide with sulphide of ammonium; a *white precipitate* of sulpho-cyanide of ammonium is formed, and on the addition of perchloride of iron to this, a *blood-red* solution results, which is discharged by corrosive sublimate.

The general method adopted, however, is to distil the contents of the stomach at a *gentle heat*, and collect the rising vapour in a receiver, which is kept cool by being placed in cold water. If the amount be very small, caustic potash or nitrate of silver may be placed in the receiver, so as to fix the acid by the formation of the cyanide of potassium (KCy) or the cyanide of silver (AgCy).

Tests.—(1) The *silver* test; nitrate of silver (see above). (2) The *sulphur* test; sulphide of ammonium and perchloride of iron (see above). (3) The *iron* test; first add liquor potassæ to the acid, then a proto- and a per-salt of iron, and lastly a drop or two of strong sulphuric acid; *Prussian blue* is developed.

When dealing with the acid in the form of cyanide of potassium, it will not be necessary to add caustic potash to this test.

Correspondence.

The Editor wishes it to be distinctly understood that he is not in any way responsible for opinions expressed by Correspondents.

TO THE EDITOR OF THE "*Guy's Hospital Gazette.*"

ENGLISH VIPER BITES.

Brighton,
September 25th, 1878.

DEAR SIR,—Are the bites of an English adder generally fatal? I well remember hearing Mr. Cooper Forster mention, in a lecture some four years ago, that there were no authenticated cases on record in which a human being had died after being bitten by one of these reptiles. Coming from a part of the country where they are by no means uncommon, and having been brought up from a child to dread them on account of the deadly effect of their bites, I was exceedingly struck by the remark.

The lecturer further went on to say, that a person having received the venom into his system, becomes mentally prostrated from extreme terror, but invariably recovers.

Since this lecture, whenever an opportunity has offered, I have made inquiries of country surgeons and others, but though I have been told of many cases of viper bite, I have never heard of a single fatal one, though all the patients have been at the point of death. Southdown shepherds say that they not usually lose a sheep from adder bites.

I annex an extract from the *Sussex Daily News* of Saturday last, which is the only fatal case I have ever met with:—

"Fatal Bite by a Viper near Amberley.—Three young men, named Mortimer, Forbes, and Gordon, were crossing the Downs near Guildford to Amberley on Thursday morning, when, as they were sitting on a bank, Mortimer was bitten in the hand by a black viper. Before Amberley was reached Mortimer was seized with serious symptoms, and expired in great agony at a village publichouse. All three were engaged as clerks at a bank in the City."

If anybody will relate any fatal cases they have met with themselves, or have got from good authenticated sources, with your permission in the *Gazette*, they will greatly oblige,

Your obedient servant,
FREDERICK BLAKER.

VOLUNTEER CORPS.

Dear Sir,—Allow me through the medium of your columns to bring under the notice of our first and second years' men the new company of the Thirty-eighth Middlesex (Artists) Volunteers now in process of formation, and which is to consist of medical students and public school men only.

Drills, by the permission of the treasurer and superintendent, will be held at the hospital, immediately after Physiology Lecture on Wednesdays. The uniform (light grey with black and silver facings) is provided by the Corps.

Full particulars will be given by any of the recruiting committee, or by

Yours faithfully,
GEORGE PILKINGTON.

"THERAPEUTICS."

Sir,—You were kind enough to publish in your number for August last a few remarks of mine on the principle "*similia similibus curantur*," which encourages me to say one word upon the above heading, as before, from an entirely theoretical, unbiassed, and student's point of view.

One of the greatest disadvantages of our hospital teaching is, that we are taught so little about functional diseases and their teatment, and I think that possibly our great consulting physicians are, perhaps, not the best able to teach us about them.

The great value of the consulting physician is, that having for years seen case after case in the wards and then in the post-mortem room, they have been able to verify their diagnoses, or find in what respect they were incorrect. In this way they have obtained a wonderful power of diagnosing diseases, and the general practitioner is only too glad to avail himself of their experience in difficult cases.

On the other hand, the general practitioner, who may have all the abilities of the consulting physician, has devoted himself more especially—it may be, for a large number of years—to the art of curing his patients, and very particularly relieving their functional disturbances. But are the consultants so willing to receive help from his therapeutical knowledge as to relieving the minor aches and pains which may render life miserable, as he is to benefit by their acquaintance with pathology? "No," they say, "how can a man be able to treat a disease properly which he is unable to diagnose?" and, perhaps, they add, "Frequently I have been called in to see cases where the diagnosis of the general practioner was entirely at fault." Granted; and it is for the very reason that the general practitioner has sometimes difficulty in his diagnosis that they are called in; but there are an immense number of cases where he is able to form a correct diagnosis, and after long experience and many trials has found out remedies of which the consultants themselves are ignorant. In these remarks I specially refer to functional diseases. If what I have said is true, it would be of great service to the profession at large, and to those just commencing to practise in particular, if those general practitioners who have thoroughly good qualifications, and who have been years in large practices, would from time to time publish the results of their experience as regards the treatment of diseases, especially those cases which are not hopelessly incurable.

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GUY'S HOSPITAL GAZETTE,
NOVEMBER, 1878.

OGSTON'S OPERATION FOR GENU VALGUM.

Among recent advances in Surgery, few branches have made such rapid strides as that comprised under the term "subcutaneous osteotomy." Taking origin in Adam's operation, in which the neck of the femur is divided subcutaneously (when the femur has become anchylosed at a bad angle) it was extended by Gant to division of the femur below the trochanters (when the neck had become absorbed); by Volkmann to division of the femur lower down for the correction of deformities about the knee; and by Billroth to the tibia and fibula for the cure of rachitic deformities of the leg. Adam's operation was introduced before antiseptic surgery came into vogue, and in principle it is subcutaneous. A small opening being made above the great trochanter, a narrow saw is introduced, and the neck of the femur divided without the introduction of air. By this operation it was first shown that living bone-dust does not excite suppuration if left in the soft tissues, but becomes absorbed in the same way as blood when not exposed to air.

The introduction of antiseptics has emboldened surgeons to divide bones more freely, and especially has it encouraged them in such operations on bones as those in which it is impossible to exclude air. Excisions of joints are now performed at greatly diminished risks, and compound fractures are regarded with far less anxiety.

Ogston, of Aberdeen, in the operation which he devised last year with the object of correcting the deformity of extreme knock-knee, has been encouraged to go further, and to add to a division of bone another apparent complication, viz., the opening of a joint. One can imagine with what horror the proposal to perform such an operation would have been received fifty years ago. An open wound of the knee-joint, complicated with fracture of the femur, and sawdust in the joint! Yet, if we may judge from the cases which we have seen, it not only succeeds admirably in correcting the deformity, but is attended with scarcely any constitutional disturbance.

The operation was first performed in this hospital by Mr. Lucas on the 27th of August last. The patient was a boy eleven years of age, who had extreme genu valgum of each leg, so that, when the knees touched, the legs formed an angle of 60°. He was unable to walk without iron supports, owing to the knees crossing and throwing him down. The operation was thus performed:—An ordinary scalpel was introduced on the inner side of the thigh, about two and a half inches above the lower edge of the condyle, and made to enter the joint in the notch between the condyles. Adam's saw was then passed along the knife into the joint, and the knife being withdrawn the condyle was sawn through obliquely just short of actual separation. The leg was then forcibly straightened, which caused the condyle to give way and slide up the femur, at the same time that the deformity was remedied. The leg was afterwards secured to an outside splint. The operation was performed antiseptically. No elevation of temperature followed. Movement was commenced three weeks after the operation, and he is now able to move the joint freely in its improved position. The other knee has since been treated in a similar way, and is progressing favourably. Mr. Lucas has since performed the operation in four other cases—once dividing both knees on the same day—and in no case has any suppuration or any constitutional disturbance of importance followed. It has also been performed by some of the other surgeons.

If the success of this operation continues to be such as the early cases would seem to promise, we may hope in the future never again to see an adult with crooked legs. Subcutaneous osteotomy, almost without risk, will correct the bowing of the legs; and Ogston's operation, apparently equally safe, may be relied upon to straighten knock-knees of the most hopeless kind.

A CASE OF INTESTINAL OBSTRUCTION.

OPERATION.—DEATH 10 DAYS AFTER THE OPERATION.

Reported by Edwin Roper, Clinical Assistant.

J. M., æt. 46, was admitted into John Ward, under the care of Dr. Mahomed (acting for Dr. Hilton Fagge) on Saturday morning, August 17th.

Family History.—Good.

Previous History.—Was formerly a soldier, and served part of his time in India, whilst there he was troubled occasionally with his liver; except this has always enjoyed good health. Never had dysentery or constipation.

Occupation.—Is a water-side labourer, his work being to carry heavy weights, he sometimes carried as much as 2½ cwts. Has always been a free drinker.

Persent History.—This morning when he arose he felt perfectly well, but had not been up long before he felt a curious feeling in his abdomen, he took some Gin and Peppermint water to relieve the pain, but it got worse, and in consequence he came to this Hospital for advice, and was seen in the surgery and given Mist. Diarrhœae, he went away intending to go to his work, but the pain in abdomen became so acute that he returned to the surgery and was seen by the House-Physician, who admitted him.

On admission.—Patient is a fairly well nourished man, with an anxious expression. He complains of acute pain in the abdomen, more especially in the epigastric region, and here the pain is increased by

pressure. Has vomited twice, and this augmented the pain. His legs are drawn up, and his abdomen is hard and drawn spasmodically towards the vertebral column. His bowels were open this morning. Lungs, heart and other organs apparently healthy. Temperature, 98·4°. Pulse, 80. Hot fomentations to abdomen. Milk and Ice.

August 18th.—Pain less this morning, and confined to the epigastric region. Nausea ceased. Aspect improved. Skin cool. Tongue dry. Bowels not open. Temperature, normal.

August 19th.—Patient says that he is in no pain, but describes it as a soreness, which is confined to the epigastric region. Bowels not open.

August 20th.—Has tenderness in epigastric region, which is increased by pressure. Aspect much improved. Tongue moist. Sleeps well. Temperature, normal. Bowels not open. Soda water, ice, and beef tea. ℞j. Pot. Bromid. gr. xv. Aq. chloroformi ʒj.

August 21st.—Haustus Senna ʒiss. statim. Bowels not open. Pulse, 80.

August 22nd.—The pain in abdomen increased during night, but he states that it is less acute this morning. Hot fomentations re-applied. Bowels not open. Tr. nucis vom. ♏v. Tr. opii ♏x. Sp. Chlorof. ♏x. Aq. Menth. P. ʒi. t. d. s. Pulse, 72.

August 23rd.—All the pain in abdomen has gone, and there is no tenderness on pressure. Bowels not open. Pulse, 80. Tr. Opii ʒss. Ol. Ricini ʒss. Aq. Menth. Pip. ʒj. Ft. haust. Ordered statim.

August 24th.—He had a draught containing opium and castor oil last night, and his bowels were open once afterwards; the motion was hard, scanty, and of a chocolate colour. Patient this morning has an anxious expression, his voice is feeble and hoarse, he has not been able to sleep during the night on account of the acute pain in abdomen, which is increased by pressure; he has also been unable to keep either soda water or ice down; immediately he swallowed one or the other they were forcibly expelled, followed by great pain.

The diagnosis was now made that this case was one of Intestinal Obstruction.

In the afternoon the patient was seen by Dr. Pye-Smith, with Dr. Mahomed, who, after consulting together, thought that the treatment at present indicated was opium and belladonna, and that surgical interference was not yet required. He was therefore ordered Pil. Opii gr. j. Ext. Belladonnæ gr. ¼ omni 3tis horis. Enema Saponis hac nocte.

Evening.—There is marked fulness in the right Iliac region, but no particular tenderness. Temperature, 99·8°. Pulse, 80. Skin cool. Tongue furred. No sickness.

August 25th.—Bowels were open twice after Enema. The first motion consisted of a small amount of fæcal matter, some mucus and part of Enema. The second consisted only of mucus and Enema.

He still complains of pain in the abdomen, which is now becoming localised, being almost confined to the right Iliac region, and in this region may be felt a marked swelling with dulness on percussion.

Afternoon.—Was seen by Mr. Jacobson, who thought that the symptoms pointed to some form of incomplete intestinal obstruction, possibly a retroperitoneal hernia, a band, or some partial nipping, but not complete strangulation of the small intestine. No external hernia. Rectum empty and normal.

August 26th.—Is in great pain this morning in the abdomen, it being now almost confined to the right Iliac region, and on palpation there can be felt a swelling, dull on percussion, which corresponds to distended cæcum. He has been sick this morning, and also during the night. On examination it is of greenish color, but is not stercoraceous. Bowels not open. Temperature, 98·4°. Pulse, 108. Urine scanty, and high colored. Specific gravity, 1012. No albumen.

Afternoon.—Patient was seen by Dr. Hilton Fagge, who expressed as his opinion that the symptoms were more like Typhlitis, causing obstruction, of which he had seen three cases recently, he therefore did not think that the patient was suffering from an acute or complete obstruction from any of the usual causes, but he thought the best chance for the patient was to abstain from surgical interference, which might prove ineffectual as well as dangerous, and to give him the opportunity of recovering by means of opium.

August 27th.—Is in less pain this morning, but there is still a slight swelling in right Iliac region, which on pressure is not so painful as it was yesterday. During the night his bowels opened once, the motion was of a chocolate color, copious and loose. He says that this gave him great relief for a time. He was sick three times, vomited matter now stercoraceous. His expression has improved. He complains of great thirst; tongue is dry. Temperature, 99°. Pulse, 80.

August 28th.—Complains of a gnawing pain in abdomen, the swelling in right Iliac region has gone, also the tenderness on pressure. His bowels have been open *four* times during the night, the first motion was scanty, and consisted of three small hard pieces containing bile, and about the size of a walnut; the other three motions were liquid, and of a light brown color, no blood. He still complains of great thirst. Micturition improved. Tongue furred. Morning temperature, 97°. Pulse, 80. Evening temperature, 98·4°. Pulse, 84.

August 29th.—Had stercoraceous vomiting during the night, this morning is very exhausted and complains of great pain in epigastric region, his abdomen is somewhat distended, and on passing the hand lightly over it, the small intestines can be felt. His expression is anxious, and his voice is very feeble and hoarse. His bowels were open once during the night, and on examination the motion is scanty, liquid, and of a buff color. Tongue furred. Pulse, 100. Temperature, 97°.

Evening.—Is in great pain in abdomen, has been

sick again, which is slightly stercoraceous, but not so much as that previously. He complains of great thirst. The pain in epigastric region occurs now in paroxysms, and while it lasts is so acute that he rolls about the bed, stating that it feels as if his intestines were being drawn forcibly out. His skin is cold, especially hands and feet. Temperature, 96°. Pulse, 100. Hot water bottles to both feet.

August 30th.—Passed a restless night on account of acute pain in abdomen. He says that he felt a frequent desire to defæcate but was unable to do so. Still very thirsty. Tongue furred. Temperature, 97°. Pulse, 96.

Afternoon.—Was seen by Dr. Pye-Smith, Mr. Colley, Mr. Jacobson and Dr. Mahomed, who urged an operation, on the ground that the symptoms pointed beyond doubt to an organic obstruction of some kind.

3·30.—Patient being under the influence of chloroform was removed from the bed on to a table at the end of the ward, where a very good light was obtained. The pubes having been shaved, the chest and limbs covered with warm blankets, the knees being relaxed over a pillow, the following operation was performed antiseptically by Mr. Jacobson:—

An incision, about 3½ inches long, made vertically in the right Iliac region, commencing about an inch above Poupart's ligament, and passing upwards just outside the middle of the structure. The aponeurois of the external oblique having been cut through, the fleshy parts of the two subsequent muscles were divided, the fascia transversalis and peritoneum were divided together by raising them with forceps and opening them with the knife held horizontally, this opening was then enlarged to admit a finger, on which the two layers were then slit open to an extent corresponding to the superficial incision. No very marked protrusion of the intestines followed, and the cæcum was first examined with the finger, and no evidence of suppuration or ulceration about this or the appendix found. The internal abdominal, femoral, and obturator rings were next explored with a view to seeing if any small hernia had escaped detection; the finger was next swept upwards, and just to the left of the incision a distinct band was found running down towards the false pelvis and continuous above with the mesentery, under this band could be felt tied down a very dilated loop of intestine. On an attempt to bring the band in view, it gave way, and the upper end was ligatured with cat gut. The strangulated loop now at once came into view, with a distinct pressure mark upon it. The intestine here being marked by a thickened ring (to the feel somewhat like a small pylorus). Around this ring the peritoneal coat was slightly ulcerated, and the immediately neighbouring intestine marked with a particle or two of lymph. No other signs of general peritonitis apparent. Wound brought together with deep quill and silver sutures.

The above incision was made as the mischief appeared localised to the right Iliac region. No vessel required ligature. Any exposed intestine was carefully covered with lint (the smooth side of the lint), wrung out of warmed carbolic acid lotions.

August 30th, 6 p.m.—Has been sick, vomited matter slightly stercoraceous. Says he has slight pain in abdomen, but feels very much relieved since operation.

Evening, 8 o'clock.—Still has slight pain in abdomen. Has not been sick again: and about 4 ozs. of urine drawn off, which gave him relief. Liq. Morphiæ Hydrochlor gr. ⅓. Hypodermic. inject.

10 o'clock.—Patient is now asleep, and breathes quietly.

3 a.m.—Patient is now awake, and has passed about ℥ ij of urine. He states that the pain in abdomen is considerably less. Skin warm. No sickness. Has had some iced water, and a teaspoonful of brandy.

August 31st.—Is very drowsy, complains of pain in right Iliac region over seat of wound, but the pain in epigastric region has gone. Tongue furred. No sickness. Bowels have not been open. Has great thirst, and slight cough. Pulse hard. Temperature, 97°. Pulse, 88. Ordered T. opii ♏ xv. Succus Limonis ℥j. Ft. haust: 3tis horis, instead of pill.

4·30.—Wound was dressed to-day, under spray. On removing the dressings there was no discharge, the edges were pale; it was dressed as before. Evening temperature, 99°. Pulse, 96.

September 1st.—He slept at intervals all night, had no pain except when he moved. His bowels were open twice; both motions were scanty and liquid, being of a buff color. He states that he had no pain whatever while passing them. His aspect has improved. Skin warm. Tongue furred, but moist. Morning temperature, 99°. Pulse, 96.

September 2nd.—Slept at intervals all night. His bowels were open twice and once this morning, being the same in character as those previously. He had during the night about two-thirds of a pint of Liebig's Extract of Beef, which he took well, and did not feel sick afterwards; he also had ice water and brandy every two hours. He is in no pain this morning, except when he moves. His voice is still feeble. Tongue furred, but moist. Still great thirst. Temperature, 98°. Pulse, 80. Respiration, 20.

Afternoon.—The wound was dressed again, and coming from the loose part of the wound there was a slight purulent non-offensive discharge. Evening temperature 99·8°. Pulse, 112.

September 3rd.—Bowels open once this morning, motion similar to that passed on September 1st. From this date the patient lost ground. Diarrhœa set in and continued obstinately, the bowels being open repeatedly day and night. The temperature never rose above 98·4°.

On September 9th he died at 11 p.m., the symptoms

having pointed to an irrecoverable condition of that part of the intestine which at the time of the operation was found constricted.

Post-mortem.—Made sixteen hours after death. Post-mortem rigidity well marked. The lungs presented at both apices, calcareous patches with fibroid thickening around. The rest of the lungs were healthy.

Heart healthy, as also liver. On opening the abdomen the omentum was in parts adherent to the intestines. The intestines shewed some peritonitis but it was not general; in parts they were slimy. On removing them ten feet from the Pylorus in the left Iliac Fossa was found a blackened portion which extended for about five inches, and in this part there were two distinct constrictions, being three inches apart, one inch of the intestine above. First constriction was black, and one inch after second constriction was also black; passing now on to the immediate neighbourhood of the wound, the intestines around it were adherent to the abdominal wall. The intestines were now removed, and injured portions examined. On being opened at both the constrictions the mucous membrane formed a kind of valve, which on being stretched easily tore.

This case presents several points of interest. First on account of the obscure nature of the symtoms, and the difficulty at arriving at the diagnosis of intestinal obstruction. In the first few days no symptoms warranted it; and it was only then made certain by administration of purgatives. Secondly, it is of interest as illustrating the tendency to remission of symptoms and apparent improvement even when the obstruction is practically complete; which not unfrequently occurs in these cases. Thirdly, it demonstrates that in some cases at least operative interference must be correct treatment, for there is no doubt had this case been operated upon before the intestine had become so severely injured that it would have been almost certainly successful. Fourthly, it enforces the lesson if an operation is thought desirable it must be done early, or utterly abandoned; the middle course is dangerous to the patient, and unjustifiable in practice, as either injury to the bowels or peritonitis is certain to be the result if delayed.

Had this case proved at the operation to be one of intestinal obstruction resulting from Typhlitis it was proposed to open the small intestine as near the cæcum as possible, or even the cæcum itself if it could be reached, this would probably have given at least as fair a chance of recovering as leaving it alone, for the danger of operation would have been counterbalanced by giving the cæcum physiological rest, and so preventing perforation.

NOTES ON CLINICAL SURGERY.

MR. COOPER FORSTER. October 23rd, 1878.

First case.—The patient is a young woman, 24 years of age, in good health. About seven weeks ago, whilst riding on a horse, she was thrown off, and pitched on to her elbow. The joint was greatly swollen, and very painful, with loss of all voluntary movement. She was attended to by her own doctor, who put the arm up in a right-angled-interior splint, and kept it in that position for five weeks. At the end of that time it was taken down, but neither the patient nor the surgeon could move the forearm or the arm in any direction, and he accordingly advised her to come up to Guy's.

On admission, a week ago, chloroform was administered, and the arm forcibly extended, during which process many adhesions were felt to give way. Since that time, however, the patient has not gained any voluntary power over the forearm, and it was in this state that she was brought into the theatre. Chloroform was again administered, and Mr. Forster again flexed and extended the forearm.

Mr. Forster then proceeded to lecture on injuries of the elbow joint, and commenced by laying down two rules to guide us in in such cases.

1.—Always place joint in that position which will be most useful in case of complete or incomplete anchylosis occurring; *i.e.*, the flexed position.

2.—In such cases always call in the aid of some other surgeon, so as to avoid unmerited blame in case of a bad result.

To the first rule he could make one exception, to the second none. The exception to the first was, of course, the case of fractured olecranon. In such cases the extended position was, necessarily, the one to adopt, but even then flexion should be begun very early, and in case of inflammation should be adopted at once, regardless of the patient's wishes, or of the pain it might cause. Mr. Forster then went on to point out how it was such injuries were so often attended with loss of motion, more or less complete; and he commenced by reminding the students of the anatomy of the lower end of the Humerus, namely, that there were four different centres of ossification, which were not completely united till about the 20th year, each of which might be knocked off and placed in some abnormal position, so, of necessity, causing more or less impairment of motion; for the same reason fracture was the rule below twenty, dislocation the rule above that age. It was easy for us to see how such injuries must cause a bad result, but not so easy for the public, and numbers of surgeons had earned unmerited abuse in such cases, and this is why he so strongly advised us to call in the aid of some brother practitioner.

In this case the surgeon had adopted the right mode of treatment, and erred only, if at all, on the side of excessive caution, namely, in keeping the arm in splints too long. The line of treatment he would advise was as follows:—First, to manipulate the bones into as good a position as possible, then place it in the

flexed position on a right-angled splint, and to keep it there for three weeks, but no longer, at that time the arm should be taken down, and passive movement commenced; the patient being encouraged to use it himself, as soon as possible, by practising lifting light weights off the ground, &c. What the precise injury in this case was Mr. Forster did not pretend to say, it might have been a dislocation, or more probably a T shaped fracture, viz., a transverse fracture above the condyles, with a vertical fissure running between them into the joint. But whatever it was the same line of treatment was to be followed, namely, reduction, the flexed position, with early movement.

FOOTBALL NEWS.

The Annual General Meeting of the Football Club was held in the Anatomical Theatre, on Thursday, October 3rd, and was numerously attended. Mr. F. J. Elliott was voted to the Chair. The financial state of the Club gave great satisfaction: at the commencement of last season the Club was £19 in debt, this year the retiring Secretaries leave the Club with a balance of £10 to the good. It was unanimously agreed that the subscription this year be 5/- instead of 7/6. The caps have been awarded to Mr. E. Penny and Mr. J. H. Lister, and the applause with which this announcement was received plainly showed that the awards had been rightly made. Mr. J. N. C. Davies-Colley has again kindly consented to act as President and Treasurer of the Club.

The following Officers were elected for the ensuing season:—

Captain of the first XV.	... ...	J. H. LISTER.
Captain of the second XV.	... ...	J. R. ATKINSON.
Secretary	... ...	H. G. ASHWELL.

Committee: L. STOKES, W. GROWSE, F. J. ELLIOTT, A. SCOTT, J. A. FRASER, J. BOSWELL.

The opening match was played at Blackheath, on Wednesday, October 9th, instead of the 5th, as at first arranged, having been put off on account of the match between Blackheath and Gentlemen of Kent, for the benefit of the Abercane Colliery Explosion Fund. There was a good muster, both of first year's and senior men. Sides were chosen by Messrs. Lister and Veitch, and after a well contested game Mr. Lister's side proved victorious by one goal and three tries, to one goal and one try. Some good form was shewn by one or two first year's men.

GUYS *v.* CLEVEDON.

Played at Blackheath, on Saturday, October 12th. Guy's winning the toss chose the upper goal, and Blogg kicked off for Clevedon. The game soon became very fast, but at half-time the only advantage to either side was two touch-downs for Guy's. On changing ends a series of loose scrimmages took place in the centre. Clevedon, aided by some good runs by Rodwell, forced Guy's to touch down twice, and soon after time was called.

For Guy's.—Browne, Growse, and Harvey.

For Clevedon.—Sharples, Cuff, and Rodwell played well.

Sides.—Guy's: J. H. Lister (Captain), F. Wilkinson, A. Jeyes, W. Growse, A. R. Milligan, Dunn, Browne, Burt, Hunt, Mead (forwards). R. Harvey and T. W. Long (½ backs). C. Spong (¾ back). J. Shepherd and J. B. Howell (backs).

Clevedon.—R. H. Sharples, Layman, A. Pelliat, W. Cartagin, R. Smythe, V. Smith, Mullins, A. P. Marsden, E. Cuff, and J. H. Gerves (forwards). E. H. Rodwell and H. C. Pratreath (½ backs). W. Edwards (¾ back). A. Bunn and C. C. Blogg (Captain) (backs).

GUY'S *v.* BLACKHEATH.

This annual match was played at Blackheath, on Saturday, October 19th, and we are sorry to say resulted in a most crushing defeat for Guy's. This was chiefly owing to the bad form shown by several of the Guy's men in not turning up. We may here mention the regret we feel at the lack of enthusiasm shown by Guy's men of late when compared with that of former years.

The match itself needs no description, for in spite of the efforts of Lister and Jackson, Blackheath won by ten goals and one try to nothing.

It is only fair to mention, as a slight excuse for such an exhibition on the part of the Hospital, that Blackheath played one of their strongest teams, whereas Guy's were represented by a second-rate team of twelve men.

Sides.—Blackheath.—L. Poland (back); L. Stokes and C. C. Clarke (¾ backs); G. W. Burton and Harrison (½ backs); G. F. Vernon, A. Budd, G. Budd, H. D. Bateson, Bradley, A. Spurling, H. W. Smith, Richardson, Robertson, A. K. Marshall.

Guy's.—C. Spong and J. B. Howell (backs); C. Blatherwick (¾ back); G. H. Jackson and B. Whyte (½ backs); J. H. Lister, J. Boswell, A. A. Jeyes, Dunn, Hunt, H. Mead and R. Cuff (forwards).

GUYS II. *v.* QUEEN'S HOUSE II.

This, our opening match, was played at Blackheath, on Saturday, October 12th, on their own ground. The game was fast, and was for some time stubbornly contested, but finally victory rested with us by one goal and one try to nil.

This result was due to the good all-round play of our forwards, and the capital back play of Blatherwick. Flanagan kicked the goal in fine style.

The team consisted of:—T. R. Atkinson (Captain); Shillingford, Flanagan, Trevor, Minter, Arnott, Pearce, Jeyes, and Handland (forwards); Dixon and Cuolahan (½ backs); Blatherwick (¾ back); Edwards and W. F. F. Davies (backs).

GUY'S II. *v.* THE GNATS.

Played at Woolwich, on Saturday, October 19th. In the early part of the game our men were not on the ball as they might have been, and accordingly our opponents scored two tries, both unsucessful.

After half-time we played up better, and just before the call of "time" obtained a try, which Flanagan converted into a goal. This, however, was disputed, and as neither side was inclined to yield, the game was left.

1 goal (disputed) to 2 tries.

The following played:—T. R. Atkinson (Captain), Shillingford, Flanagan, Dendy, Minter, Arnott, J. W. Pilkington, H. A. Davies, and Pearce, (forwards); Dixon and Cuolahan (½ backs); Martin (¾ back); Edwards and W. F. F. Davies (backs).

JUNIOR GUYITE CLUB.

"The *Cock* may craw,
"The day may daw,
"But aye we'll taste the barley bree."

The Fourth Annual General Meeting and Dinner of the above Club took place at the Criterion, on Wednesday, October 2nd. In the unavoidable absence of the President (Mr. P. Gilbert) the arduous duties of chairman were discharged in a masterly manner by Mr. W. Cock. The following gentlemen having been proposed and seconded as candidates for membership of the Club were submitted to a ballot and duly elected:—Messrs. E. Bevans, J. Hammersley, J. Mackern, A. Scott, C. Knox-Shaw and Sykes. Officers having been appointed for the ensuing year, and some other formal business transacted, the members present devoted themselves each to the worship of his own particular divinity. Lyœus claimed the suffrages of all, and the far darting one was likewise to the fore; nor is there reason to doubt that more than one embraced the opportunity of depositing a last offering upon the neighbouring shrine of Aphrodite.

GUY'S HOSPITAL GAZETTE,

NOVEMBER, 1878.

PROBABLY the most important faculty for the Student of Medicine to possess is observation, and for this reason, that medicine at present is chiefly a deductive science, most men come up to the hospital with the injunction "to observe" ringing in their ears; and almost the first thing impressed on them by their teachers is also to observe, it is consequently not to be wondered at that the junior men follow this advice literally, but perhaps not quite wisely. Now we are not going to quarrel with the advisers and say that the advice "to observe" is bad, we too think the student is to begin to observe as soon as ever he enters a hospital, but we most decidedly object to seeing our operating theatre and out-patient rooms crowded with men who ought to be "observing" in the dissecting-room, or in the museum. It is a pitiful sight to see our theatre crowded with men who often can see but little and understand still less of what is going on in the arena. Again, nearly all last summer the usually solemn decorum of the Obstetrical out-patient room was rudely broken into by some dozen or more of very junior men indeed, who of course, and very justly too, could not be allowed to take part in bi-weekly mysteries. They, at any rate, if observers at all, were superficial observers, and we cannot help thinking that they might have been learning more somewhere else. Yet they were acting on advice we believe. But there are other considerations besides those relating to themselves. There are always a certain number of men preparing for the final M.R.C.S. and L.R.C.P., to whom observation at out-patients is peculiarly valuable. These, owing to the present somewhat imperfect arrangements in this department, and on account of the crush of men, often do not reap the full advantage, the same applies to the operating theatre. It is a pity that those who advise this universal system of observation do not at the same time advise *how*, *when*, and *where*. So vast and varied is the list of medical studies now, that a systematic method of learning is absolutely essential to forming an intelligent idea of our profession. It is beginning at the wrong end to hear a disease discussed which attacks structures we scarcely even know by name, or to look at an amputation very much as we look at a leg of mutton being carved; we deny *in toto* that experience gained in this way is worth anything. The first year certainly is not the time to attend at out-patients, and the third year is quite soon enough to begin studying practical gynæcology.

How to observe is an important question. Besides using our natural senses, note taking is a very valuable help to the memory, especially at out-patients, where cases are seen only for a short time. Though it is difficult at first, after a time by persevering it is possible to get into a perfectly accurate and rapid method of noting down the principal points in a case, an invaluable acquisition for future practice; it is curious and interesting to go over one's old note books, and to see what trifling things are put in at first, and what important matter left out, and to see also the gradually increasing accuracy. Regular attendance at out-patients with notes, and the two appointments of Surgical and Medical Ward Clerk ought to make one proficient in case-taking, perhaps the most important part of our hospital training. As Professor Lister truly remarked just before he left Edinburgh, we have immense resources in London, let not his sneer that we do not make good uses of them apply to us Guy's men.

THE PHYSICAL SOCIETY.

October 5th, 1878. DR. WILKS in the Chair.

The first Saturday of the new Session brought round the Physical Society meetings.

Dr. WILKS took the Chair, and as an introduction to the forthcoming meetings spoke in his usual pleasant way of the work of the Society, drawing attention to the length of its existence, its usefulness to students as being an opportunity of discussing what they had heard taught in the wards, and above all as to its great usefulness in teaching men the art of public speaking. It is at the Physical Society that a man wears off the nervousness inherent in every one who makes his first essay at public elocution. He had a letter from an old Guy's man (Dr. Newman), well known, even in the remembrance of some of the senior men, as a racy debator at the Physical Society. Dr. Newman is now in the Colonies,

and is occupying a high civil position, mainly owing to his powers of elocution, which he asserted in his letter was first obtained at "the dear old Physical Society." Dr. WILKS ended by urging all Guy's men to attend and make the most of the opportunity thrown open to them.

MR. DOWNES was then called upon to read his paper, of which the following is an abstract:—

The reader begun by noticing some of the remedies that had been recommended for Acute Rheumatism, and thought that their numbers and variety was accounted for by the fact that in many cases the natural tendency of the disease was to go on to recovery. Wishing to compare the results of treatment by Salicylic Acid with those where the sole remedy employed was rest in bed, dieting and careful nursing, the writer had tabulated 100 consecutive cases, occurring in the latter part of 1876 and 1877, and which had been treated with Salicylic Acid, and for the others he was indebted to a series of 41 cases, published in the "Reports" for 1865, which had all been kept by Dr. Gull on Peppermint Water alone. It was observed that as Dr. Sutton stated that the cases reported by him, were not selected, but that Dr. Gull had pursued the same plan of treatment for a certain time in his ward, neither were these tables the result of any selection. All the cases that had been under Salicylic Acid in 1876, and two wards of those in 1877, were taken in the order in which patients came into the Hospital. It was shewn that the average duration of the stay in Hospital was longer now than in 1865, and that the total number of cases of heart disease was about equal to the number in those treated by Mint Water. The exact figures are tabulated below. The time in acquiring perfect freedom from pain was seen to be somewhat lessened under Salicylic Acid, but it was pointed out that the dates were taken exclusive of relapses, the inclusion of which would have considerably increased the average. A record of the temperature in each case was made, but there was no opportunity of comparing it with temperatures under Peppermint Water, inasmuch as in Dr. Sutton's cases no record was taken. Cases were read in which Salicylic Acid failed either in reducing the Pyrexia, or in lessening the pain, and these were parallelled by cases reported in the *Lancet* during 1876 and 1877. It was argued that since in both Dr. Sutton's cases and those of to-day, by far the largest proportion of heart complications were present on admission, it was fallacious to attribute to Salicylic Acid the power of stopping Heart disease, for it was shewn in many instances where no Salicylic Acid had been used, a patient coming into the Hospital with a healthy heart, went out with one; and while six out of the hundred cases developed heart disease during residence, three only of Dr. Sutton's 41 cases did so, thus bringing the averages very near. In the larger number of cases the dose of Salicylic Acid was twenty grains every two hours, in some it was given every three hours, in very few every four hours, or three times daily. In conclusion, the reader thought that the effect of Salicylic Acid had been over estimated, and that the most conclusive way of finding out its real value was by instituting comparisons between large numbers of cases treated by it, and equal numbers treated in other ways, and not by observation of individual cases.

Average duration of stay in Hospital in Dr. Sutton's cases ... ... 27·8 days.

Average duration of stay in Hospital in those under Salicylic Acid ... ... 40·85 days.

Six shortest sojourns in Hospital under Mint Water ... ... 9, 7, 8, 11, 11 days.

Six shortest sojourns in Hospital under Salicylic Acid ... ... 9, 18, 18, 17, 20 days.

Percentage of 1st, 2nd, and 3rd attacks.

In cases under Salicylic Acid, 52 per cent. 1st, 25 per cent. 2nd, 3 per cent. 3rd.

In cases under Mint Water, 41 per cent. 1st, 13 per cent. 2nd, 12½ per cent. 3rd.

Average duration of stay in cases by Salicylic Acid, where no heart complication existed, ... 36·2 days.

Average duration of stay in cases by Mint Water, where no heart complication existed, ... 30·2 days.

Number of days from admission to date of freedom from pain, Salicylic Acid... ... ... 9·5 days.

Number of days from admission to date of freedom from pain, Mint Water ... ... 14·2 days.

It is to be noted that Dr. Sutton considered freedom from pain to mean the last day during residence on which pain was felt, thus including in his average the duration of the relapses, while I took my average to the first day's freedom, thus excluding relapses, of which there were 17, so that although on this point there is a gain, yet it is not so great as appears by the figures above.

Number of Salicylic cases with heart disease on admission 71

Number of Salicylic cases where it was developed in Hospital 9

Total number of cases with Cardiac complication, 80 per cent.

In six of these nine cases it is distinctly stated that the heart sounds were clear on admission, in the remaining three cases there was either some vagueness in the report, or as in one of Pericarditis, there was pain over the sternum on admission.

Analysis of cases of heart complication:—

12 cases of Pericarditis (one developed during stay).

41 cases of distinct Systolic Mitral bruit.

2 cases of roughened, first sound at apex (one developed during stay).

5 cases of Systolic bruit (position not recorded).
1 case of Diastolic bruit (position not recorded).
12 cases of Systolic Aortic bruit.
5 cases in which there were many complications.

Number of cases under Mint Water which had heart disease on admission ... 25·62 per cent.

Number of cases under Mint Water which developed heart disease during stay 3·8 per cent.

Total number of cases with Cardiac complications, 28·70 per cent.

In the absence of Mr. Sheldon Mr. HORROCKS opened the debate. He thought statistics utterly useless—especially these—as many of Mr. Downes' cases had had only one or two doses of the acid. Looking, as he did, upon rheumatism as a blood disease, and seeing that salicylic acid was rapidly secreted by the kidneys, he recommended larger doses—twenty-five grains every two hours till the pain ceases, and then every six hours. He thought no patient efficiently treated unless deafness or other symptoms showing the effect of the remedy were induced. He said in twelve hours the pain disappeared under salicylic acid, and in twenty-four the patient was cured, and in a fortnight he might resume work.

Mr. SCOTT entirely agreed with Mr. Horrocks. He was not a believer in statistics. He never saw salicylic acid fail. Salicylic acid took five days to be entirely eliminated, and in cases where the treatment was not sufficiently carried out a relapse could be anticipated on the sixth day after stopping the treatment. He had not found it successful in chorea.

Mr. SHAW, being early impressed with the uselessness of drugs, was glad to find in salicylic acid a remedy which appeared trustworthy. With twenty-five grain doses the pain disappeared in twenty-four hours. He did not think a case thoroughly treated unless deafness was induced. If delirium ensues the remedy must be stopped. He had seen two such cases. In the earlier case small doses were given, and as these entered into Mr. Downes' statistics, he did not think his conclusion could be relied on.

Mr. PRICE had seen a case of acute rheumatism greatly benefited by salicylic acid. He had analysed a specimen of salicylic with the object of finding some material to explain the occasional bad effects. A small quantity of phenol was found. He inquired whether paroxybenzoic, an isomerical compound, had ever been used.

Mr. WAINEWRIGHT thought contamination with carbolic acid might account for the bad symptoms.

Mr. MORRISON thought it due to Mr. Downes to say that as the reports of the year were not collected he must have incurred much extra work thereby.

Further remarks were made by Dr. Mahomed.

Mr. DOWNES then replied.

A vote of thanks was proposed and carried to the author, another to the president, Dr. Wilks, after which the meeting adjourned.

Saturday, October 19th.

MR. C. KNOX SHAW in the Chair.

MR. R. PARRY read a paper on "Rest and Position in the Treatment of Medical Cases," of which the following is an abstract :—

Rest is as essential in medical as in surgical cases, but not capable of such wide application, on account of the functions of the organs with which the physician has to deal.

Complete rest by wrapping the joints in cotton wool and bandaging them affords immense relief in Rheumatic fever.

In mental diseases rest is an essential part of treatment. The time when the brains enjoy most perfect rest is sleep, hence insomania means want of cerebral repose. Treatment of insomania depended on removal of cause. Causes may be due to morbid excitability of cells, or to an amount of vascularity incompatible with sleep. Senile insomania belonged to latter class. Opium, bromide of potassium, ergot, digitalis, cannabis indica, are among the most important drugs which relieve insomania. In chronic insomania drugs should be given cautiously.

Heart's period of rest usually occupies about $14\frac{1}{2}$ of the 24 hours. Increasing number of heart's beats, decreased amount of rest: hence value of digitalis, aconite, belladonna, and other drugs.

Aneurisms generally treated (*a*) by Potassium Iodide, this is said to diminish number and force of heart's beats, (*b*) by complete rest and limited diet, or (*c*) galvano-punctore. Venesection is often of great value as part of treatment. In inflammation of serous membranes, the amount of lymph thrown out depends on amount of friction undergone. Hence value of strapping in pleurisy, of opium in pericarditis and peritonitis In peritonitis occurring in typhoid fever, complete rest to intestines by opium is the only chance of recovery: subsequent constipation must be gently dealt with.

Chronic laryngitis treated by as complete rest as possible. Mr. Bryant has suggested tracheotomy in these cases.

Complete rest in bed with as complete functional rest to part as possible is the guide in treatment of ulcer of stomach, gastritis, &c. Rest may be obtained to stomach by administering enemata, or prescribing alkalies. Bismuth also acts by producing rest to stomach. In kidney diseases the skin should be freely and persistently acted upon in order to relieve the diseased kidneys of a portion of urine work. Acute desquamative nephritis after scarlet fever is due to an extra amount of work thrown upon previously slightly weakened organs.

Failure of treatment in phthisis is generally due to the continual movement of the diseased part.

Mr. DOWNES thought the general principle of the paper was well seen in nature, any cause increasing the period of work and diminishing that of rest produced disease. In inflammation of serous membranes the lymph produced glues the parts together, so producing rest. In the case of the pericardium the result for a time was useful, but its later effects were disastrous. In phthisis he thought strapping the affected side might be useful. Those vessels bearing most strain were most diseased, as seen in splenic, cerebral, and coronary arteries. He did not think a chill to the surface was sufficient to cause congestion of the kidneys, as there was not sufficient blood in the skin to materially alter the condition of the internal organs.

Mr. W. E. STARLING thought most papers were practical or

ultra scientific; of the former class was Mr. Parry's. He considered it a great improvement to have given up the black draught and blue pill of our forefathers and substituted rest as a therapeutic means.

Mr. SHELSWELL thought Mr. Starling had not done justice to our forefathers. In doubtful cases rest was the best course, but in all cases of obstruction the black draught was the proper treatment.

Mr. GRAVES drew attention to the great benefit of blood-letting in cases of mitral disease and aneurism.

Mr. BAYES thought rest had an influence in albuminuria, as such cases passed more albumen during the day than the night. He thought that digitalis prolonged the diastole of the heart, and it was during this time that the coronary arteries were filled; but this was still an open question. He suggested that pain in gastric ulcer might be partly accounted for by the contact of the stomach with the spine.

Mr. R. SCOTT thought rest was indicated in brain affections; a dark room, freedom from noises, and elevation of the head were useful. In typhoid and other such cases pneumonia was frequently found; this he thought was owing to the position, and inquired for means to prevent it.

Mr. FLANAGAN thought much good might be done by strapping. He thought a chill sufficient to cause congestion of the kidneys. He thought tracheotomy scarcely justifiable to relieve the larynx. In advising rest in overworked brains he advocated the use at the same time of other exercises.

Mr. E. A. STARLING mentioned a case of stricture of the œsophagus, which was greatly relieved by feeding the patient on enemata for a week.

Mr. SAUNDERS suggested the employment of splints in rheumatism. He thought rest from talking was very useful in pleurisy. He spoke from personal experience.

After some remarks by the chairman, a vote of thanks was passed to Mr. Parry, after which the meeting adjourned.

THE PRACTICE OF MEDICINE.—1567.

It is interesting, if not something more, to look over the medicine of the past, it is not wasting time, it brings a lesson with it. From the great advance of the present over the time of our retrospect—from the method approximating to precision now in use, compared with the former affected precision—from our truer knowledge of our defects, we may infer that medical science may advance beyond us at least as much as we are beyond the knowledge and practice of, say, 300 years ago.

I am led to this line of thought by the perusal of a black letter treatise of 1567. The Urinall of Physicke, composed by Maister Robert Recorde, Doctor of Physicke. The book went through several editions from 1548 to 1651. Robert Recorde was a "learned Physician and Mathematician." He was at Oxford in 1525, Fellow of All-Souls 1531, Doctor of Medicine 1545, and he taught Arithmetic and Mathematics at Cambridge. He wrote the "Castle of Knowledge;" the "Ground of Arts," an arithmetical work which went through many editions; the "Pathway to Knowledge," a geometrical work; the "Urinall of Physicke;" a "Herball;" and a supplement to the Ground of Arts, the "Whetstone of Witte."

He was one of the first in the country to adopt the Copernican system, showing him as a man rather before his time; and as Physician to Edward VI. and Mary, he appeared to be in the front rank of his profession.

Notwithstanding these advantages, he ended his days in the King's Bench Prison in Southwark, then near St. George's Church, where he was confined as a debtor,—confinement for debt or any other mischance in our prisons as they then were, meaning too commonly, death from gaol fever or starvation.

For a man of some exact knowledge, as his reputation as a teacher of arithmetic and geometry at Cambridge would imply, his work on medicine is very disappointing,—if his was the *best* kind of practice, what must the *worst* have been? It really was not in any great degree essentially better when I first joined the classes at Guy's and at Webb Street, in 1830. The Stethoscope and the Bright and Addison methods were in a light way ridiculed in our own schools. But the dawn, evidently a late dawn, was opening upon us; Southwood Smith, Armstrong and Grainger were real men; Sir Astley Cooper, Cline, Tyrrell, Key, Bright, Addison, Arthur Aikin, Blundell, were real men; and new methods, not empirical, not enforced by authority of name, were rapidly having way—I do not name one of the highest, Elliotson, of Thomas's, whose wonderful clinical lectures I often heard, because the balance of his mind was gone, and he gave the weight of his great name to vagaries equal to the worst of Robert Recordes,—still we were struggling into light. This book of 1567, the Urinall of Physicke, was founded upon the prevailing notion of judging diseases and prognosticating by the urine; to which Dr. Recorde adds, the pulse.

When Sir Thomas More's friend waited upon him to tell him that his execution was appointed for the morning, Sir Thomas in his usual vein of philosophic pleasantry, held up his water to the light and said to his friend, "I perceive this man might have lived longer if it had pleased the King,"—it was a common method of prognostication. But the methods adopted not only did not yield much real information, but must have often misled. A glass vessel was invented, it was called an urinal; it was to have a short neck and a wide body "like the bladder of a man," to be of "pure clere glasse, not thicke nor greene," it was to be graduated and marked with lines. The body was to be like divided into an equal number of parts, and the water in the urinal would tell the condition of the body in its parts, its diseases, and how events were to turn out.

The Doctor talks of three concoctions going before the generation of urine,—meate and drinke, concocted in the stomach and so made into "rude bloude,"—"this rude bloude was wrought againe, and made more perfecte in the Liver,—again purified in the 'hollow vayne,' 'the Aorta,' and separated from the blood, as whey from milk, it was consigned to the Renes (kidneys) and altered 'perfectly into urine,'—now it passed by the 'water pipes,' (ureters) into the bladder."

The patient is exhorted to study his own body, so as to answer his physician intelligently, he is not to expect to be told of all things at first sight "more like as if he had to do with a god than a man." The great clerk, Plutarch, is cited to show what a shame it was for men to observe "the crieing of crows and the like in beasts and birds, neglecting to mark the motions within themselves, and the alterations preparing unto sickness. A man should know his own natural pulse and observe his own water." A Sir Thomas Elliott is noted as a shining example, but a "rare one," he had built a castle of health for Englishmen, and had put forth books in the vulgar tongue, whereby men might learn to govern themselves.

Specially concerning the urine, it is noted that there are four ways of judging—substance, colour, quantity, and contents. It is stable when it keeps the same day by day,—there is order, as black after white, black after green, and so on. The urine is thin when you can see the joints of your fingers through the water, and otherwise thick.—Colours; are white, pale, flaxen, yelowe, redd, and blacke,—all these differences have important significations. They are further sub-divided, still with significations, as for instance: green water may be light greene, greene as grasse, starke greene, darke greene, and popingay greene. The Doctor notices sediment, scuym (scum) and cloud,—now and then there are herys (hairs) like huskes or like bran,—there are bubbles and an oilines on the top.

The student is well informed of the differences of urine in

different men, *e.g.*, the cholerike, the melancholy, the phlegmatic.

He is not left in ignorance of signs, *e.g.*, that thick urine betokeneth openness of the water pipes and vaynes; the whiteness as of milk betokeneth stone; if thick and red and coming little, it is an evil token; if with deafness and headache, pain in neck and sides of belly, the patient shall have the falling evil (epilepsy) "within a seaven night;" thit l and blewe urine, the patient shall escape his grief, whateree it may be. It will be useless to particularize further, ekn arbitrary signs and combinations and consequent empirical judgments are very numerous. The astounding summarycw that the observer is to note the parts of the urine as shosvh in the urinal, as corresponding with the human body. The highest urine corresponds to the highest parts of the body—the head and adjacent parts. The middle region of the urine corresponds to the middle region of man's body, as the breast and the bowels. The lower or "nether" parts of the urine concern the parts of a man downwards from the bowels. The Doctor remarks, a good saving clause this, that when from certain changes in the urine, the lowest parts invade the upper, a like change may be found in the body. Although I feel after reading this book of 200 pages as attentively as I was able, that I may have been conning over little else than arbitrary jargon, I cannot undertake to say that the rear eno grains of wheat among the chaff. I cannot help believing although I cannot altogether see it, that these particular prognostications in connection with definite signs or symtoms might, in the mind of the educated physician-empiric of the day, have had some practical outcome or reality. If so, it must have been confined to the one man; his method, as shown in his book, is not definite enough for transmission to a succeeding student.

I can fancy it probable that even the great modern work of Dr. Prout's on the same subject may bye-and-bye be adjudged to be as far behind the then advanced knowledge as Robert Recorde's is behind ours.

At the end we have the remedies:—

For Stone—Sour almonds, earthworm's excrements, bryony, caper bark, dock root, parsley, St. John's Wort, goat's blood, a hedge sparrow, and 28 others.

To provoke urine.—Basil, cubebs, flower de lyce, garlick, leeks, ginger, honey, valerian, &c.

For Strangury.—Calamus, cedar berries, washed turpentine, wild fennell, &c.

For the flux of urine or "Pissinge Evil" (Diabetes).—Apples, comfrey, endive, dates, myrtle berries, night-shade, pomegranate, &c.

The incontinence of urine among children in bed, comes, our author explains, "of the dissolution of that muscle which should kepe in the urine."

This will suffice to shew the practice of a King's Physician in the the time of Edward VI.

One cannot be surprised that the book was issued from the sign of the "Brazen Serpent," or that the author died in the Bench.

W. RENDLE.

THE ABUSE OF MORPHIA.

The subcutaneous injection of morphia, which in professional hands has gradually grown into such a vast power for good to suffering humanity, has lately threatened to become to almost an equal extent a power for evil. In England, fortunately, the powers of the drug are but little understood outside the medical world; but in France and Germany they are more widely known to the general public, who, always on the alert for a new form of excitement—an untried inebriation—have overstepped the legitimate limits of its use, and created for themselves a new sensual indulgence. Instances are by no means infrequent of patients who, in spite of the most serious derangement of their health consequent to the abuse of the drug, have found all their resolution inadequate to the task of discontinuing it. Snch persons can, as a rule, only regain their health and self respect by a voluntary and absolute surrender of their personal liberty to medical surveillance. Their recovery is then usually rapid and complete, and relapses are not common; when, however, they do occur the difficulties of treatment are so increased as to render the case almost hopeless.

That so potent a drug cannot be used unskilfully and indiscriminately without serious consequences is sufficiently obvious. The phenomena resulting from its long-continued use are, however, in some cases so anomalous, in all so different from what one would expect *à priori*, that the subject is worth our notice from a forensic point of view, and the more especially as the psychological phenomena connected with the sudden withdrawal of the drug have been confused in some cases with symptoms of pathological nerve change, and in others with delirium potatorum.

The symptoms referable to the physiological action of morphia may be conveniently grouped under two heads:—

I.—Symptoms caused by the use of morphia.

II.—Symptoms caused by sudden abstinence from morphia.

1.—The abnormal conditions resulting from the abuse of morphia are, as we have remarked, extremely variable, both in kind and degree, in different patients; and although it is no doubt true that the constant use of the drug is often speedily followed by constitutional disturbances more or less characteristic, yet it is certain that cases have occurred of patients who have taken large doses during many years, not only without symptoms of functional derangement, but with some apparent benefit. And this uncertain and seemingly erratic effect of a drug, whose activities when not abused are as tractable as they are potent, depends certainly less upon the amount used than upon some esoteric individual idiosyncracy, akin, perhaps, to the patient's susceptibility to alcoholic exaltation.

Wendell Holmes, in one of his charming works, mentions music, poetry, religious excitement, and "oftenest love" as intoxicants. Ninon de l'Enclos said that she was so easily excited that her soup intoxicated her, and De Quincey quotes a medical student who made a patient "drunk on a beefsteak." The spasmodic cerebral action induced by opium is much more constant in intensity than the excitement caused by its alkaloid, and (perhaps in consequence) attended by far graver results, yet even this is modified by race to a very great extent.*

One of the most striking instances of apparent immunity from punishment after the long-continued use of morphia is that of Geheimrath Dr. von Nussbaum, professor of surgery at the Munich University. This gentleman informed me—and he made no secret of the fact—that during a period of more than ten years he has taken morphia subcutaneously to the extent of from eight to ten grains daily, and certainly his wonderful intellectual and physical powers appear to have suffered no obvious impairment. In addition to a large con-

* In spite of all that has been said or written with regard to the pernicious effects of opium consumption on the Chinese and other races who have inherited more or less of tolerance for the drug, it is most probable that its temperate use is scarcely more injurious to either the individual or nation than the consumption of alcohol or tobacco. Moreover, opium eating compares favourably with dipsomania, inasmuch as the latter vice is assuredly the more destructive to organic functional activity, and hardly less difficult of treatment. Compare the sad history of Edgar Poe with the brilliant career of Coleridge, the former a dipsomaniac, the latter an opium eater. And De Quincey, whose quotidien allowance averaged at one time about eight thousand drops of tincture of opium, conquered the habit by sheer force of his masculine will, and reached a good old age. Yet the remarkable work in which he sketches the history of his self-deliverance leaves one with the conviction that most men bound by the chain which he broke would have remained helplessly and hopelessly fettered to the vice.

sulting practice he has the whole of the surgical work of the Munich General Hospital. He is a brilliant and successful operator, a prolific author, and one of the best and most popular lecturers in Germany. His pupils are contracted to points, but his accommodation is not affected, and his vision is good. His appetite and digestion are as good as most men of his age enjoy, his complexion is clear and healthy-looking, and his heart's action normal. I am not aware what reason he assigns for his first adoption of the habit, but I well recollect his remarking on one occasion at a clinical lecture, that he was accustomed to use his syringe immediately before any operation requiring more than usual care or dexterity.

When morbid conditions do result from the use of morphia they probably depend on neuroses of the sympathetic vaso-motor systems. The patient's sufferings begin very gradually, and go on to varying degrees of intensity; probably no two persons ever noted quite the same symptoms, or could ascribe their chief distress to a like cause.

The pupils are generally contracted, but not by any means necessarily so; sometimes they are unequal, and now and then, but rarely, enlarged: they usually react well to the stimulus of light, but power of accommodation is impaired.

Diplopia is rare. The skin may become waxy and inelastic, but seldom shows diseases, although herpes and allied affections are said occasionally to appear. The subcutaneous adipose tissue is said to waste, but the patients I have seen had not suffered in this respect.

There is generally a disagreeable amount of thirst with loss of appetite, especially for animal food, and nausea. The bowels may be constipated, but often remain normal, and in a few cases there has been diarrhœa. Most patients suffer from anæmia, and slight anasarca; dyspnœa and palpitation of the heart are rare, and the pulse is generally very good. The salivary and cutaneous glands are active; indeed, the copious perspiratious constitute in some instances the most distressing symptoms. The urine is generally normal) in very severe cases there may be albuminuria, but this is rare), it always contains morphia, and deflects the polarized ray to the left: the test (of which we shall speak later) is the reduction of an alkaline solution of sulphate of copper. The generative organs are usually affected; there may be impotence, complete or partial, with seminal emissions; the latter are especially obstinate on abstinence from the drug. The menstrual function is mostly in abeyance, and there will probably be—particularly in women—other evidences of serious derangement to the nervous system, such as trembling of the limbs, flushing, hyperæsthesia, paræsthesia, and the various forms of neuralgia.

A curious phenomenon experienced by patients who take morphia in considerable doses is a peculiar difficulty of micturition, less marked than, but akin to, the condition described by Paget in his "Clinical Lectures and Essays" as "Stammering of the Bladder." There is never either absolute retention or painful micturition, but a minute or two will elapse before the patient can commence the act, even though his bladder be quite full; and the flow is arrested ten or a dozen times before its completion. But this complaint is not limited to those who take morphia habitually; indeed, it is less marked when the drug is well tolerated, and a single dose may suffice to induce it.

Enlargement of the spleen, which is occasionally noticed in sufferers from chronic morphia poisoning, is possibly mostly owing to coincident malarial affection. Dr. Levinstein, director of the "Maison de Santé" at Berlin, however, considers that intermittent fever is not unfrequently directly due to morphia poisoning. He says the symptoms resemble accurately those of ordinary tertian ague, and are readily controllable by quinine, although the complaint is apt to reappear at the slightest exciting cause, even during the continuance of the febrifuge. It rarely assumes any than the tertian type; the maximum temperature averages 103·5°, and the attacks, however obstinate before, cease immediately on the discontinuance of the morphia.

An extremely disagreeable accident connected with the use of morphia, and one that is attended with symptoms sufficiently alarming to those who experience it for the first time, is the injection of the drug into a vein. The accident is fortunately a rare one; its more frequent occurrence in such patients who have become tolerant of morphia may be explained by the fact that a series of injections in any part of the body, but especially the abdomen, is always followed by much dilatation and congestion of the neighbouring surface capillaries. Thus injections into these abnormally vascular parts find their way into the blood stream almost as quickly as those poured directly into a vein. Dr. von Nussbaum, who might claim for himself as De Quincey did, the distinction of the "Alpha and Omega" of morphia takers, was the first to record the symptoms attending the accident, as it happened to him. He subsequently made the experiment of injecting morphia into his basilic and cephalic veins, in quantities varying from one to two-thirds of a grain, for the purpose of verifying his former observations.

About twenty seconds after the injection of the fluid the patient experiences sharp pricking and tingling, first in the lips, and then in the head and back of the neck and shoulders. Then comes a rush of blood to his head, which feels as if it would burst; his heart beats violently and somewhat irregularly, his face is flushed, his carotids throb, and his whole condition resembles that of a patient under the influence of nitrite of amyl. If the injection be larger, or if the needle point happen to penetrate exactly into a larger vein the symptoms may be more serious. The patient will suffer intense pain in the temples and spinal region; he will fall to the ground, and possibly remain unconscious for some minutes. The accident has never caused more than temporary inconvenience, and in most cases the patients will have completely recovered in half an hour. More or less headache and vertigo may, however, persist for a day or two.

The quantity of morphia that may be given to some patients without danger of establishing a tolerance of the drug is perfectly astonishing, and this peculiarly the case in neurotic affections as tetanus or neuralgia; indeed, it may be considered a safe rule that morphia exhibited as a pain-queller, even during long periods of time, may be withheld in convalescence without distress to the patient. De Quincey mentions the case of a gentleman, a Mr. Harreott, who, to subdue the pain of gout, took on the first night fifty grains of opium, on the second sixty, and on the third eighty, with no untoward results.

The most convenient and least painfnl parts of the body for hypodermic injection of any fluids are the upper arm, near the insertion of the deltoid, and the lower part of the abdomen on either side, but not in the middle line. The solution should be injected into the adipose tissue and never into a muscle. Suppuration will not occur once in a thousand times if the solution be clear and the syringe in good order. The best strength for the solution is ten per cent., or morphia 0·1 to 1·0 of water; but the stronger the solution the better it will keep. It should have a slight acid reaction.

(To be continued.)

WE are glad to find that St. Thomas's is following in our steps and providing a refreshment stall in the out-patient room. We have done so for some few months, and it seems to answer its purpose. Good tea and coffee, and milk, with bread and butter, etc., can be obtained for reasonable sums. Many patients have to wait a very long time in the out-patient rooms. It must be a great boon, and it is extraordinary it was never before thought of.

Correspondence.

The Editor wishes it to be distinctly understood that he is not in any way responsible for opinions expressed by Correspondents.

TO THE EDITOR OF THE "*Guy's Hospital Gazette.*"

Dear Sir,

May I be allowed to add a few remarks to your notes on the Physical Society, in October No. of the *Gazette*.

While fully agreeing with you as to the folly of essayists to try and confound their hearers by showing a profundity of knowledge *obtained from books* not composed by themselves, and laying stress on the necessity of producing as much as possible original papers. I do not quite concur in your remark that "to get on, or to have a brilliant career, it is a *sine quâ non* to belong to the Physical Society."

It seems to me that the very essence of mental power is to produce a good original essay, and to be able to discuss it efficiently from all points of view.

If by a "brilliant career" is meant to get prizes while at the hospital for simple learning what is found in text books, of course one must acknowledge the distance between this so-called brilliant career, and the writing of original essays, but I would beg to remind those who look with indifference on the Physical Society that life does not consist of passing a series of examinations in which the man with the highest marks obtains the highest place, but rather (and this can be proved by numerous examples), he who possesses the qualities of patient observation, pure reason and sound judgment. At the same time urging all to work hard, since *Knowledge is Power*.

I am, yours truly,
W.E.R.

NOTES OF THE MONTH.

GUY'S 1873 CLUB.

The Annual Dinner of the above Club which was to have taken place this year at St. James' on Thursday, October 31st, has been unavoidably postponed.

MRS. NEWBOLD, who has during the last three years held the arduous and responsible post of Sister in Accident Ward, left us on Friday last, November 1st. Before her departure the House Surgeons and Dressers in the ward, both past and present, presented her with a gold watch as a token of the esteem and affection in which we are sure she was held by all who had in any way the pleasure of working with her during her term of office here.

APPOINTMENTS.—LUCAS, R.C., B.S., F.R.C.S., has been appointed Surgeon to the Metropolitan Life Assurance Society, *vice* Hilton, deceased. BRYDEN, R. T., M.R.C.S., has been appointed Senior Assistant House Surgeon to the Sheffield Public Hospital and Dispensary. WELLS, A. G., M.R.C.S., has been appointed House Surgeon and Apothecary to the Essex and Colchester Hospital.

NOTWITHSTANDING increase of the fees we are able to announce a good entry, and from the number of men who contested in the scholarships we augur well for the 1878 year. There are 115 new men altogether, 13 of these however only enter for special classes, hospital practice, &c. This is but little below what they were last year.

WE regret to announce the death of Mr. Edward Simpson, forty-two years dispenser at Guy's, who died on the 6th Oct., 1878, in his 71st year.

During the last month the following Fractures and Dislocations have been treated in the Surgery (Male and Female).

Fractured	Clavicle	15 cases
,,	Ribs	15 ,,
,,	Radius	7 ,,
,,	Ulna	4 ,,
,,	Radius and Ulna	4 ,,
,,	Humerus	5 ,,
,,	Meta-Carpal bone	3 ,,
,,	Phalanx	1 ,,
Dislocation of Shoulder, including 2 of the subglenoid variety and 2 subcoracoid		7 ,,
,,	Thumb	1 ,,
,,	Radius and Ulna... ...	2 ,,
,,	Phalanx	2 ,,

ENTRANCE SCHOLARSHIPS.

THE Science Entrance Scholarship this year was awarded to Mr. Edwin James Onions.

THE Classical Scholarship was awarded to Mr. William Arnison Slater.

ON DUTY FOR NOVEMBER.

House Physicians, E. Clifford Beale, G. Mackern. *Junior House Physician*, J. C. Uhthoff. *House Surgeons*, J. Hammersley, C. Knox-Shaw. *Junior House Surgeon*, R. S. Wainewright. *Senior Resident Obstetric*, C. Keep. *Junior Resident Obstetric*, R. R. W. Oram.

RESIDENT DRESSERS.

November 6th.—Mr. J. Briscoe (Mr. Bryant).
,, 13th.—Mr. Barnard (Mr. Durham).
,, 20th.—Mr. E. Penny (Mr. Howse).
,, 27th.—Mr. A. G. Maylard (Mr. Cooper-Forster).

CLINICAL SURGERY CLASS.

Mr. Howse has commenced the above class for the present Session on Saturdays at 1·30 o'clock. The class is principally for men about to present themselves for their 2nd College Examination, but is open to all students. It is held in the Operating Theatre.

GUYS HOSPITAL STUDENTS' BIBLE CLASS.

The first ordinary Meeting of the Session will be held on Thursday, the 7th instant; subject, 1 John, i, 1—ii 2. The Class will also meet on the 21st of the month; subject, 1 John ii 3—11. The meetings are held at Hibernia Chambers, London Bridge, from 7 to 8 p.m., and are open to all Students who recognise the Divine authorship of the Scriptures.

THE CONVERSAZIONE.

Unfortunately last month notice of the Conversazione was unavoidably omitted from the *Gazette*. It is even now pleasant to call to mind our annual gathering of old and new Guy's men. The main object of the Conversazione is to bring together past and present Guy's men, and to serve as the introduction of the new men to their Alma Mater. The exhibits serve to heighten the interest of the evening. They were this year quite up to the average. There were the usual collection of microscopes and specimens, surgical instruments and pictures. But amongst the novelties on this occasion, which naturally attracted most attention, we must mention, on the ground floor a beautiful picture illuminated by lime light, "Evening in the Moon" by Herr Winkler, exhibited by Messrs. Gammon and Vaughan, and the phonograph lent by the London Stereoscopic Company.

Up stairs there was an exceedingly prettily arranged dais surrounded by beautiful plants, on which the Treasurer was to give away the medals and Prizes. It had a charming effect on ascending the staircase.

Of the exhibits in Astley Cooper Ward we were particularly struck with the array of Microscopes of the best makers; an ingenious mechanical fountain shown by Mr. W. Reeve; a patent bed lift sent by Messrs. Child and Hende, and a collection of Filigree and Plaqués Berlin Iron Work, lent by Dr. Braxton Hicks.

Great credit is due to Dr. Mahomed and Mr. Bovill who assisted him, for their careful demonstrations of the Plethysmograph for indicating the relative oscillations of the blood volume.

The Treasurer, assisted by the staff, at 10 o'clock, gave away, amidst much applause, the medals and prizes awarded at the end of the summer session. We were unable, owing to the number present, to get near enough to hear the speeches, but from the happy way they were received, we judged they were opportune and to the point.

EXAMINATION OF CANDIDATES FOR HER MAJESTY'S NAVAL & INDIAN MEDICAL SERVICE. August, 1878.

EXAMINATION PAPERS. ANATOMY & PHYSIOLOGY.

Mr. Busk.

1.—Write a full description of the superior maxillary bone; its connexions and relations to muscles, nerves, and blood vessels.

2.—Give the origin and insertion of the following muscles, and the nerves by which they are respectively supplied:—

a. Constrictors of the pharynx.
b. Tensor and laxator tympani.
c. Complexus.
d. Levator anguli scapulæ.
e. Short Muscle of the thumb.

3.—Describe the arteries of the upper and forearm; their course, relations, and anastomoses.

4.—Describe the various modes in which nerves terminate peripherally, give instances of each.

5.—What are the chief differences in the conformation of the cranium between the Negro, Mongol, and Esquimaux.

SURGERY. Mr. Pollock.

1.—Describe the symptoms of commencing caries of the three or four lower dorsal vertebræ; its usual course, and at what points pus may present itself. Describe the treatment to be pursued in the various stages of this disease.

2.—Describe the varieties of Nævi; and the treatment to be adopted, according to their character and situation.

3.—What are the most common causes of fistula-in-ano? and the most appropriate constitutional and local measures for its relief?

4.—Describe the symptoms of inherited syphilis:—
1st. As it occurs in infant life,
2nd. As it is found in more advanced age; and what is the treatment to be pursued under each condition.

5.—Describe the general characteristics and minute structure of cancer of the lip. By what symptoms may it be distinguished from a chancre of the lip, and what are the measures to be adopted for its removal?

6.—What are the most common causes of retention of urine —1st. In childhood. 2ndly. In old age? Describe the treatment to be adopted under each condition.

MEDICINE. Dr. Aitken.

1.—Explain what is understood by the term "visceral syphilis." Mention the viscera usually implicated. Describe the general and microscopic anatomy of such lesions, and their relation to the special normal anatomy of each of the organs or parts you mention.

2.—Name the sources or causes of internal obstruction of the bowels. Describe the more important symptoms, and their diagnostic value in distinguishing the forms of obstruction from each other.

3.—Give a full and detailed account of the specific morbid phenomena which results from advanced chronic kidney disease and retention of urea.

4.—Describe the symptoms, progress, and treatment of a case of simple, unilateral, idiopathic pleurisy.

5.—What is the meaning of the term "menorrhagia"? How do you judge of the amount of profuseness of menstruation? What are the causes of menorrhagia, (1) constitutional or general; (2) local or organic? Describe the treatment of profuse menstruation, the causes being constitutional or general.

6.—What are the physiological properties and medicinal uses of "Tartar Emetic" (*antimonium tartaratum*)? What are the preparations of it, according to the British Pharmacopœia, the several uses of these preparations, and the doses or quantities of them? With what substances is Tartar Emetic incompatible; and what are the antidotes in cases of poisoning by it.

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GUY'S HOSPITAL GAZETTE,
DECEMBER, 1878.

NOTES ON CLINICAL SURGERY.

MR. BRYANT.

Mr. Bryant chose for his subject the case of a boy on whom he had operated the day before. The following is the history of the case and its treatment, taken from the report of G. R. Marsh, Esq.:—

Family History.—Good. Patient was well till three months ago, when he was attacked by rheumatic fever. Fourteen days after commencement the left hip and elbow, with the right wrist, became stiff and flexed, and have remained so ever since.

On Admission.—Patient is a healthy, well-nourished lad, fourteen years old; his right wrist is anchylosed in a flexed position, and slightly pronated. The contiguous extremities of left humerus and ulna are firmly united together, and the elbow joint is immovably fixed in the flexed position at about an angle of 100°. The movements of pronation and supination are limited to about one-half their normal amount. The left thigh is flexed, abducted, and rotated outwards so as to form a right angle with the trunk, the joint being firmly anchylosed. There is some thickening in front of hip joint, and the left knee cannot be fully extended.

The patient suffers no pain; heart sounds clear and distinct.

November 19th.—Patient was brought into the theatre and placed under chloroform. The left forearm was first firmly extended, and then the fibrous adhesions in the joint were broken through. The left forearm could now be extended in a line with the arm, and a freely moveable joint thus obtained.

Next, Mr. Bryant firmly grasped the right hand in one hand, and, steadying the forearm in his other, extended the hand, the adhesions giving way with an audible snap.

The pelvis was then fixed, the left thigh was drawn down to the median line of the body and then strongly adducted, and finally moved about in all directions.

Finally, the knee was extended, the leg placed in a long double outside splint, the left elbow in an anterior angular, and the wrist on a stright splint. Ice to be applied over the hip joint.

Mr. Bryant commenced by reminding the students of the history of the case, and pointed out especially the dates, as by the history and its duration he had been enabled to form an accurate diagnosis, and so to follow the right line of treatment. Rheumatic fever was the alleged cause of all the patient's troubles, and he saw no reason to doubt the accuracy of the diagnosis in this particular case; but he could not too often warn his hearers not to mistake for rheumatic fever a case of ostitis or periostitis; and in any case of supposed rheumatic fever, which was confined to one or two joints, it was necessary to be very much on our guard to avoid falling into such a disastrous error. Rheumatic fever was then in this case the starting-point of the mischief, and the joints had assumed their usual position, namely, the flexed position.

Mr. Bryant then went on to remind his hearers of the different pathological forms met with in anchylosed joints, but as his time was short he could only enter at all fully into one of these, namely, the fibrous anchylosis, so commonly met with as a result of rheumatism. In all acute rheumatic affections of joints there is an abundant effusion of organisable lymph into all the structures round as well as inside the joint. This hyper-fibrinous lymph was characteristic of rheumatism, and was not met with in any other form of joint affection. This fibrinous lymph might take any of three courses: — I. It might all be absorbed. II. It might break down into pus, causing disorganisation of the joint, followed by osseous anchylosis. III. It might form fibrous adhesion, within and without the joint. It was this last form that we had met with in this case, and it was on this form that he should dwell for the rest of his lecture.

The adhesions might be within or outside the joint, but the more intra-articular they were the severer the lesion. In this case, he had no doubt, the adhesions were both within and without, and so firm were they, that they gave to the hand entirely the feeling of an osseous anchylosis, the bones forming the different joints, allowing of no movement whatever. And here the benefit of paying attention to the clinical history was most strikingly shown. There was too great a tendency in the present day to ignore the history, and to trust only to the physical symptoms. The diagnoses so made might be more brilliant in some cases, but in the long run were not so sure.

In this case the physical symptoms pointed to osseous anchylosis, in that there was no movement to be obtained in any of the affected joints; the clinical history, on the other hand, would hardly allow of such a diagnosis. Osseous anchylosis, occurring so soon after the attack of rheumatic fever, unaccompanied by any sign of suppuration, was a thing almost—if not entirely—unknown. Clinical history gained the day, and through it the right diagnosis was made, and the right treatment adopted.

Mr. Bryant then passed on to the treatment of such cases, and summed it up in two rules:—

I. Give chloroform, and try to break down adhesions; failing that—

II. To perform osteotomy.

In this case, as we had seen, the first treatment was successful, but he—Mr. Bryant—had been fully prepared to perform Adams's operation on the neck of the femur. He could not recommend the forcible fracturing of bones, as some authorities did, for it was

a most dangerous procedure. It had fallen to his lot to see three such cases; one of whom escaped only by the "skin of his teeth," the other two dying of acute abscess of the joint.

But there was one form of treatment on which he had not yet spoken, but which was far more important than any he had yet mentioned, namely, the prophylactic. In any case of rheumatic fever it should be our greatest care to prevent the joint assuming such positions as would render them useless in after life in case of anchylosis occurring.

The rules for the different positions were clearly laid down in all text-books, but we must remember that to them even there are exceptions, and in all cases to inquire into the occupation of the individual, and shape the joint accordingly.

CASE OF CEREBELLAR CYST.

R. F., æt. 11, admitted into Stephen under Dr. Pavy, on November 14th, 1877.

Family History.—Good; no syphilis or phthisis.

Personal Medical History.—No previous illness.

History of Present Illness.—A year ago patient began to have shooting pains in the occipital region, lasting a minute or two, and returning every two or three hours. During these attacks the head was thrown back, and the mouth opened wide, and the patient often fell down. He always fell towards the right, and saw objects revolving from left to right. He had dizziness and trembling of the legs after the pains, but never lost consciousness.

Patient has always been slow to learn. Went to school regularly till six months ago, when he got so much worse that he gave up going. Was often cuffed on the head for stupidity; this increased the headache and giddiness.

Eyesight has been failing for the last six months. Hearing good. Has a fair memory. Has had no pain except in the head. Never any running at the ears. Attended the East London Hospital without benefit.

On Admission.—He is a well-nourished boy; complexion dark; eyelids rather puffy, pupils widely and equally dilated; apparently insensible to light. He is quite blind, but can distinguish light and darkness. No paralysis or loss of sensation; no headache. Heart and lungs normal.

November 17th.—℞ Mist. Rhei. Co. ℥ ss., ter die.

November 20th.—Optic discs pale and anæmic; vessels contracted, outlines blurred. These changes are most marked on the left side.

November 26th.—On attempting to stand with his feet close together patient sways about and falls to the right side. When he walks he throws out his right leg as if it did not belong to him.

December 24th.—Galvanised. Pectorales majores contract equally. Deltoid, biceps, triceps, and rectus femoris more irritable on right side than on left. Muscles of forearms contract equally well on the two sides.

January 1st, 1878.—Had a fall from his chair, which made his head ache.

January 2nd.—Had an attack of vomiting and headache.

January 10th.—℞ Ol. Morrhuæ ℥ ij., ter die. His gait is more tottering, and he is not so cheerful.

January 14th.—Right leg and arm weaker than left; sensation the same on both sides. Temperature, 98·4°. Bowels confined.

January 22nd—Occipital headache; no vomiting. On seating the patient in a chair, and laying his head on the left side, his eyes rolled to the left and twitched to the right. When his head was laid on the right side, his eyes rolled to the right and twitched to the left. When his head was held straight, his eyes rolled slowly to the left and twitched to the right.

February 5th.—Has been falling about a good deal, principally towards the right.

February 10th.—Optic discs greyish white, edges clearly but not sharply defined; vessels fairly numerous, of normal size; partly hidden where they come to the edge of the disc.

February 15th.—Transferred to Clinical. Incontinence of urine and fæces. Loss of power over legs has become greater. Can move his limbs slowly when lying in bed. Taste and hearing not affected. No loss of sensation. Dark lines round orbits.

March 6th.—℞ Pot. Iodidi., gr. iv.
Syrup. Limonis, ℥ ss.
Infus. Calumbæ ad. ℥ j., ter die.

There is now a tendency to fall in any direction; cannot stand up without assistance. Passes urine and fæces without knowing. Appetite good.

April 1st.—Transferred to Philip, under Dr. Moxon. ℞ Ol. Morrhuæ., ℥ j., ter die. Had a fit, lasting about two minutes; turned white and lost all strength; was not conscious.

April 16th.—℞ Mist. Rhei. Co., ℥ ss., ter die. Ol. Morrhuæ makes him sick, so it is stopped.

May 2nd.—Headache.

May 5th.—Headache.

May 10th.—Headache.

May 21st.—Had a fit. Turned red and cold during the fit, and white as it was passing off. It is doubtful whether consciousness was lost. Was quite motionless.

May 28th.—Severe headache.

June 2nd.—Fit, lasting five minutes. Became blue and cold, and trembled all over.

June 26th.—Went down in the gardens, but was seized with violent vomiting and purging.

July 15th.—Headache. Has had a good deal of

diarrhœa lately, which has been stopped by Mist. Hæmotoxyli.

September 5th.—Lies in bed quite contented, complaining of nothing. Says he is nicely when questioned. Has become very fat. Head large; dull, stupid expression of countenance.

September 16th.—Headache. ℞ Mist. Effervescentis, 6 tis horis.

September 17th.—Feels well. T. 97·6. P. 88. Atrophy of the retinæ is progressing; radiating lines of pigment cells, with vessels between, are visible; edges of the discs are not so sharp as formerly.

October 6th.—Walking powers tested. Has to be supported on both sides when he walks. Can bend his knees and hips, but has lost all power of equilibration. There is some trembling in right knee. Urine and fæces passed involuntarily or very suddenly. He has a distinct sensation of defæcation or micturition. He is remarkably cheerful, laughing on slight provocation, and often singing to himself. Suffers a good deal from toothache, in consequence of decayed teeth.

October 30th.—No change. Went out.

November 19th.—Died at 12.15 A.M., at Rotherhithe. Sickness was the only symptom noticed by his friends immediately preceding death.

November 20th.—Necropsy by Mr. Beale, House-Physician. 8 P.M.—Great excess of fluid in the cranium; ventricles distended with fluid; brain substance soft and flabby; convolutions flattened; veins of Galem distended. In the cerebellum is a cyst, rather larger than a hen's egg, and filled with clear yellowish liquid. The cyst involves both hemispheres equally, and presses down on the fourth ventricle; it has a single thin and vascular wall. Around the cyst the brain tissue has become softened and disintegrated; this involves the white matter and part of the arbor vitæ. Pons flattened.

The other organs of the body were not examined, as the inspection was a private one, by special permission of the parents. The cerebellum was brought up to the hospital and hardened in spirit. The cyst was then carefully dissected, and a small fleshy tumour, half an inch in diameter and button-shaped, was discovered in the wall. The tumour was visible from the inside of the cyst, but not from the outside. Part of this tumour was frozen and sections were made; under the microscope the structure turned out to be round-celled sarcoma.

The chief interest of this case lies in the comparative rarity of the pathological lesion. On referring to "Wilks and Moxon's Pathology" I find that such cysts are due to the widening of spaces caused by extravasated blood in the tumour.

The immediate cause of death was probably either asphyxia or syncope, the rough implication of the "nœud vital," or cardio-inhibitory centre respectively, due either to extension of softening, or direct pressure of the cyst, or pressure of the excess of fluid in the fourth ventricle. The vomiting which preceded death indicates an affection of the vomiting centre, which is obviously very closely associated with the respiratory centre.

The condition of hydrocephalus may be induced in three ways:—(1) By exudation attending ordinary inflammation; (2) By pressure of the cyst on the venæ Galeni, causing congestion and effusion; (3) By closure of the Foramen of Magendie, and consequent distension of the ventricles. In this case I think the last two causes may be assumed, for throughout the patient's stay in the hospital there is no history of inflammatory symptoms; and, moreover, at the autopsy the veins of Galen were markedly congested.

The original tendency was to fall especially to the right side, but this was afterwards replaced by a tendency to fall in any direction. This may be explained by supposing that originally the cyst occupied the right hemisphere more than the left, but certainly at the inspection the hemispheres seemed equally involved, thus bearing out the later symptoms.

I think the differences in the rotation of the eyes may be explained by the different degrees of pressure exerted by the cyst on the various parts of the cerebellum, the part most pressed upon varying with the position of the body. On referring to Ferrier it will be found that he obtained precisely similar movements on stimulating the cerebella of monkeys. Obviously, when the head is resting on one side the hemisphere beneath the cyst is subjected to much greater pressure than that above it.

The treatment in cerebellar cyst is unfortunately almost nil. In this case horizontal posture and freedom from excitement was indicated and maintained. Any excitement, whether from muscular or mental exercise, would determine more blood to the brain, and hence to the vascular wall of the cyst; more serum would thus be effused into its cavity, and thus the growth would increase in size and exert more pressure on the neighbouring centres. This theory is apparently supported by the violent vomiting and purging which came on when he was taken out in the gardens, and by the vomiting which occurred after he left the hospital, and when he was doubtless less carefully attended to.

For a similar reason the bowels should be kept regular, to assist in giving as much physiological rest as possible to the vascular walls of the cyst.

BEAVEN N. RAKE.

JOHN HILTON, F.R.S.

It would ill beseem that Mr. Hilton should pass away without some notice in the *Guy's Gazette*. For, although his retirement from the acting staff of the hospital withdrew him from the every-day notice of

the students, yet the name of Hilton will long reverberate in Guy's tradition. He was a great surgeon; a man of great power; devoted to the art and science he pursued, yet a Master, not a slave, of his art and science. A wise guide and sound teacher of young men; his character was a lesson even greater than the lessons he conveyed in speech; and he conveyed lessons so eloquently, yet in a way so little dependent upon eloquence, that all listened when he spoke, and all learned who listened.

Mr. Hilton was a great man. It matters not to him what we think of him. It is almost an instinct in us to suppose that what we think about others makes more difference to them than to ourselves. And that is perhaps true of us little people. But Mr. Hilton was a great man, and, even before he was gone, it was more important to you to get right thoughts of such a man, than to him what you might think about him; because when he came, he brought alive before you what it is worth your while, being a man, that you should be. An honest upright brave man, yet a cultured, thoughtful gentleman. Neither abashed nor regardless; neither overwhelmed nor irreverent. Some thought him rough; such a view was possible on a rough view of him, but none could deal more gently where gentleness was right; and even where he disliked he was incapable of narrow vindictiveness, or of pursuing the indulgence of revenge. For no heart was truly kinder than John Hilton's. Neither did he despise the formalities of life, but his naturally robust character would show through any mere forms. He was a gentleman, and when he held high office none could say that his office lost in dignity of manner and bearing through being held by Mr. Hilton. In short, there never was a more courteous man, although, perhaps, he was not cut out for a courtier.

Like all men who have achieved distinction there were points of nature and points of fortune in his favour. But it is worth while to notice that he had not fortune all on his side; in fact, his succeeding to the staff of Guy's was no matter of easy course. He was the first man appointed who had not been apprenticed to the staff, and this act of his appointment broke down a great monopoly, so that now the honour of admission to the staff of the hospital is open to any man who can prove his ability, and will devote himself to deserve the position of a teacher at Guy's.

As a young man Hilton travelled on the Continent. He was an excellent French scholar, and spoke that language fluently. He also visited Switzerland and Italy; all this at a time when travelling on the Continent was by no means so easy as it fortunately or unfortunately is at present.

Thus towards the knowledge of men and things. As to books, Mr. Hilton was a man of large general information. He read the best rather than the latest authors, and was not given to devouring the newest things in the transient columns of journals, where matter of doubtful value is discounted, as it were for cash, to the credit of the person whose name thus appears. He carried out before it was given Matthew Arnold's advice to read good books rather than the newspapers. Very important advice it is too.

He was remarkably precise in the use of language, exeeedingly quick in catching up any word in a sense the speaker had not perceived. But this wit of his went upward, improving the meaning and enlarging the views. His was no downward wit which defaces good matter into burlesque. Cheap triumph of folly. But he improved his friend, whilst he enlivened his friend's dulness. Dulness, indeed, was impossible around him. His repartee was brilliant and incessant, and it behoved sharp men to be a little careful what they said, or in some playful way they would find out a side of the matter of their discourse which they had not seen in so laughable a light. But it did you good, as a rule, and the subject was better aired. Mr. Hilton was a good mimic, and would "take you off" to perfection if you were worth it. In short, he was full of fun and of enjoyment of life.

Do not think all this a slight merit. It was of great importance in his character, because with all this natural liveliness he worked his way up to distinction in the stern and laborious calling of surgery. You meet plenty of Wasters about who are lively enough in their little way, but who have none of the masterly thought and continuity of purpose which makes a great surgeon; and, on the other hand, you meet a good many who achieve distinction by their thought and continuity of purpose, but have no liveliness at all. A kind of man who grows great, or rather is drawn up tall as it were, because he does not enjoy his life; finds his to-day so meagre that he is always working for to-morrow to escape it. Such men show at the top of the tree—when they get there—as sour grapes. Poor fellows; they at best find a kind of ideal, reflective, imaginary happiness that is slightly contagious amongst their own kind, and they can be just endured by company for a short time.

This was not Mr. Hilton's case. He had influence as well as power. You will distinguish between influence and power as you see more of life. There must be points in a man besides intellectual power if he is to have influence. And these points are those which constitute his acceptability to others. Yet, take care! The public may pass you over a lot of money whilst they accept you only as a kind of mountebank; and each of them soon despises himself for having liked you. But to be in some honest straightforward way thus acceptable affords the man a field for his powers to play in. He may provide himself with power by much study, so far as knowledge is power; but he must be able to adapt himself to the less serious sides of other folks' humanity if he is to be more than a sour grape, in however high a cluster.

But in whatever cluster of people Mr. Hilton

appeared you saw a strong man "all round." He was pre-eminently a strong man. No Roman legion was more completely a moving fortress, ready alike for attack or defence. It was the nature of such a man to obtain his knowledge directly and practically.

John Hilton was an observer. He was not the sort of man who could only see what he was told to see, and so he ran no risk of falling into the likeness of that frequent and ludicrous sort of men who only see what they are told to see, and see this even when it is not there: chiefly furnished with other people's mare's nests, bewildered, without trust in their own eyes and ears, and not witting whom to trust amongst the crowd of mare's nest discoverers who cackle about them.

Mr. Hilton saw for himself. He worked hard at anatomy, harder than any other man of his time or since his time, and the result can be seen in the models made from his beautiful dissections by Mr. Towne. Models of what? Models of skill and perseverance. Mr. Hilton did not mean them for Guy's men to sit over, flattening their noses on the cases; but for examples to emulate in their own dissections. They are incitements to do likewise, not merely means of "getting up the subject."

Neither did Mr. Hilton, whilst dissecting, spend his time taking whitish stuff off reddish stuff, all the while thinking of something or somebody else, like a shoemaker over his last, or a young lady knitting clouds. Those who never heard "Anatomical Jack," —for so he was called in kindly irreverence—give a lecture, may learn how far removed was Hilton's anatomical work from this common dissecting-room self-culture in imbecility, if they will take up and read carefully the small volume of his "Lectures on the Cranium," in which the name of Dr. Pavy, who took the notes of the lectures, is worthily associated with the author's; or still more, Mr. Hilton's lectures on "Rest and Pain," of which Mr. Jacobson's excellent edition is one of the most thoughtful and thought-engendering books in the profession.

With Mr. Hilton the things he saw became matters of living knowledge, for he was always upon the question "Why is this thing so? What is the end or purpose which it serves?" His was not the modern question, "How has it arisen? By what correlation of conserved forces in vast lapse of time did it evolve itself out of nothing particular?" a question which rots young surgeons. He was a good man, not a bad one; a man imbued with the conception of finality in causation. Hence his power as a surgical teacher, hence he was not drawn aside into vapid "Biology." He never showed the least taint of Troglodyte philosophy, the amateur professorship of which seems now to be epizootic amongst the very highest of apes. To him anatomy revealed designs and objects which he could further in his surgical efforts, not casual adaptations of a blind and brainless universe, begetting correlated brainlessness in the curiosity-mongers who collect a row of other specimens to link with themselves into a chain of being downwards, and so resolve into primeval mud the mystery of human existence. Mr. Hilton never lent his powers to this noble achievement. His leading conception of purpose in organisation caused him always to be adapting his own purposes for cure to the purposes of nature for maintenance and recovery. His intentions joined the intentions of a greater, and he thus did underservice, as it were, in good faith towards the sufferer and towards the greater, whom he conceived as purposing for good. How different this from the outcome of Materialism you find in those German hospitals where fresh patients are called for as "more material" when one lot of wretches have been tired out with "demonstration." A conception of the relation of patient and doctor, easily reached by science, which has cast off reverence.

To Mr. Hilton there was a purpose in the course of every nerve, in the arrangement of flesh and fibre of every muscle. He first stated the rule—"Wherever a nerve supplies a muscle, it supplies the skin over the muscle." He reached this generalization in search of the purpose that governs the apparently arbitrary distribution of nerves. He saw that there was a convenience or readiness of mutual communication between surface and motive power, which indicated the design in such an arrangement. His pleasure was in lighting upon the *principles* on which general facts of organisation are founded. How charmingly he brings out the object there is in the elasticity of the capsules of great viscera, insuring as it does, recoil when the blood-pressure is relaxed in repose, and thus securing rest for the organ. His originality found a profusion of such points to raise the study of anatomy above the mere conning of facts of neighbourhood, and to make it a study of principles and final causes; for he worked in the faith that there is meaning in the adaptations of the human frame, meaning whose intention was subject to his comprehension, and capable of furtherance by his skill when injury had disarranged the system. This is the spirit of a good surgeon, and in this spirit it is that those who are to be great surgeons in the future will again ardently study anatomy.

A life of such study made Mr. Hilton's opinion in any case most valuable, prized, and sought after. He would see the leading lines of your case. Truthful observation of symptoms and signs, with clear conception of the principles he had recognised, confirmed and enriched his judgment. And he found it worth while to be such a man as he was, even when age drew upon him, and the sweet aspirations of youth gave place to sub-rheumatism and dyspepsia. So that he did not fall into dotage and self-indulgence, but to the last fibre was sound. In his last year as quick, ready, bright as ever; and even when dying he seemed fuller of life than most men you meet when about their ordinary business.

GUY'S HOSPITAL GAZETTE,
DECEMBER, 1878.

"SOME books are to be tasted, others to be swallowed, and some few to be chewed and digested." Whilst many people confine their attentions to the first class of books, we, as students, are more immediately interested in the last, and yet we undoubtedly err if we neglect the lighter forms of literature. It is for our well being that we should have plenty of good plain solid food, which requires to be chewed again and again; to be subjected to the ferments of the lecture theatre, to the acids of the dissecting-room, and to the temperature of our own fireside until it is thoroughly digested and assimilated, and becomes an integral part of ourselves. Yet a Hodge can do all this, and we should further try to cultivate our mental palates so as to appreciate a Chateau Y'Quem.

For which is the more pleasant and useful member of society, the man who has entirely devoted his energies to grinding, neglecting literature, careless of the world around him, intent simply on his own work; or the man who, while doing his work thoroughly, yet realises that there are aims and objects in life to strive for besides passing examinations, and is not unmindful of the claims of other branches of knowledge on his attention? "Science is a *first-rate* piece of furniture for a man's upper chamber if he has common sense on the ground floor; but if a man hasn't got plenty of good common sense, the more science he has the worse for the patient.

As future medical practitioners we should remember that in no other profession can general knowledge and accomplishments be turned to so good account as in ours, and that tact and general acquirements are far more important factors than mere learning in determining whether we shall be successful in life.

While the knowledge implied in successful diagnosis and treatment is all important, yet it is more advantageous for all parties that we should be authorities on topics of general interest, rather than walking encyclopædias on the last new medical theories. What we would draw attention to is, that even when working hard the time spent in some light reading is not wasted, for it is useful in itself, and is also a great relaxation to the mind.

For it is a mistake to try to work too many hours continuously; and one can set to work with renewed vigour if there has been a break for a meal, with a chat, or a look at the papers and magazines.

Now what have been our means at Guy's for doing this? If we have trusted to seeing *The Times* at lunch, we must be as keen and as patient as a cat after a mouse in order to secure it. If we have wanted to have a chat there is, as we are all painfully aware, but one place in the hospital where it can take place, viz., in the colonnade.

Now on a wet winter's day the colonnade is not a paradise. It is not surprising, therefore, that it has been decided to start a Guy's Reading Room, with the following objects:—

I.—To give members an opportunity of seeing the principal daily and weekly newspapers and magazines.

II.—To provide a room where strangers can wait for men, instead of having to wander about the hospital in search of them, as they now too often have to do.

III.—To provide a room where members can spend the time now generally occupied in wandering aimlessly about whilst they after lunch are waiting for the Staff, or when on Saturday evening they remain for the Physical Society.

IV.—To provide stationery for members.

Such a society must surely meet with the support of most men, but more especially of those who are living in lodgings, and who naturally have but few opportunities of seeing magazines and weekly papers; and it is essential to its success that it should be well supported, for unless we have a large list of members the daily and weekly papers will consume so large a proportion of the funds as to leave insufficient means adequately to carry out the objects of the society.

In these days of ours, in which the money side of

any question is considered to be the most important, if we can show that in addition to the convenience there is also economy in being a member of this society, a man will have to hunt far for a reason why he should not become a member.

The subscription will certainly not amount to threepence a week, and yet undoubtedly almost all the men are now spending more for not a tithe of the advantages they will receive from the society.

Before long we hope to see the society in full swing, performing a function as useful in its way as those of the Physical Society and the *Guy's Hospital Gazette*, having on its books the names of as many members.

THE PHYSICAL SOCIETY.

Saturday, November 2nd. Mr. HORROCKS in the chair.

Owing to Mr. Fuller being unable to read his paper on "Gastrostomy," a clinical evening was arranged.

Mr. R. SCOTT brought forward a lad, the subject of an enlarged knee joint, which was due to congenital syphilis. He had the remains of keratitis, and had the well-known Hutchinson's teeth. It had improved very much under anti-syphilitic remedies, and was well worthy of notice to show the importance of an early diagnosis of the syphilic lesion.

Mr. PARKE next showed a case of male hysteria. The patient, a young man, had presented all the symptoms of hysteria usually met with in young women — the hemi-anœsthesia and hemi-analgesia, curious fits, and almost complete aphonia. Mr. Parke drew attention to the various remedial methods that had been used, and especially noticed the "metals treatment," and the treatment by large electro-magnets. He was now able to walk, which he had not been able to do when he first came to the hospital.

Mr. O. B. SHELSWELL wished to draw the attention of the society to a case of psoriasis. After having discussed the pathology of the disease he drew attention to the varied forms of treatment, more especially to that by chrysophanic acid, with which the patient had been treated. He also mentioned some unpleasant effects likely to be produced by the acid, such as staining the skin, and lachrymation and photobia, when used on the face.

Mr. KNOX SHAW brought forward a man who had been the subject of frostbite last winter, and had had in consequence double amputation of both legs. The stumps had never quite healed, the skin on them being red and unhealthy. He wished to point out how much more of the skin really suffered in frostbite than would be supposed; and how that in order to secure a good firm stump it was necessary to amputate a good distance beyond the line of demarcation. In this case re-amputation was proposed.

Saturday, November 16th. Mr. A. E. MAYLARD in the chair.

Mr. H. E. B. Flanagan read a paper on "Phthisis," of which the following is an abstract:—

Principally confined to the discussion of the two theories of phthisis. Without denying the constitutional origin of phthisis in some cases, yet there are many arguments which point to the infective nature of the disease, especially in those predisposed to the development of low inflammation. Out of 23 cases of general tuberculosis in the post-mortem reports of 1876-1877, in 20 there was found some old inflamed deposit in various parts of body which might have acted as an infective centre. In two of these cases there was a unilateral tuberculosis of lung spreading apparently from a caseous gland. In one of hip disease the general tuberculosis was started after straightening of hips. These three cases seemed to point to an infective origin. *Fistula-in-ano* often appearing long before symptoms of phthisis, and tubercle never found in these cases in rectum in favour of infective theory, also experiments on guinea pigs. *Hereditary history.*—Many simple inflammatory diseases are heriditary, *e.g.*, simple sore throat; probably tubercle is developed in persons predisposed to the development of low inflammations by merely an inflammatory deposit, modified according to the tissue in which it is exuded. *Common complication* of intestinal ulceration with phthisis no argument in favour of a non-inflammatory disease, for it is not uncommon to find acute inflammation of intestine with acute pneumonia, some sort of sympathy existing between the lunge and intestine. Much the same can be said of laryngeal ulceration, it being by its position and functions the larynx is exposed to irritation, which would be likely to set up chronic inflammation. Some cases quoted to show the inflammation of caseous pneumonia, especially one lately in Stephen under Dr. Pavy; also three cases which seemed to have an inflammatory origin of phthisis with diabetes. The difficulty of distinguishing between the nodules of a generally diffused cancer and tubercle was attended to.

The principal points in the diagnosis and treatment were also very shortly pointed out.

Mr. PARRY looked at phthisis in two ways, as inflammatory and tubercular; the latter not always being present. Any unhealthy inflammation may go on to phthisis. With regard to fistula-in-ano he had seen three cases, in all of which phthisis existed. In 190 of Mr. Bryant's cases he had only found phthisis in 3. Inability to take fat was an early symp-

tom. In these cases Ol. Morrhuæ and Ether were good, the latter aided absorption of fat. With regard to phthisis with heart disease, he thought the cyanotic condition militated against phthisis, in the same way as it did in chlorosis. When the sputa became drier, the cough more painful, a good prognosis was to be looked for, and expectorants avoided.

Mr. R. SCOTT thought that Mr. Flanagan did not attach sufficient importance to hereditary history. He wished to know whether phthisis was infectious, whether persons living in close proximity, as husband and wife, would be likely to infect one another. He thought poor food a more exciting cause than essential. He should let children run about in early condition. Protrusion of second rib was often seen in phthisis. Pil. Conii. Co. he found useful to check the sweating.

Mr. SHELSWELL thought there was too much tendency for students to pass over this disease. He thought that when the disease attacked the base of the lung the prognosis was better than when affecting the apex; this being due to less movement of the part, and to blood and pus not gravitating so much as when at apex. Hæmorrhage was not common in the senile form, nor in acute tuberculosis, nor was it fatal in consolidation. Instead of a bounding pulse there was exhaustion after bleeding. The Eucalyptus Globulus was said to have some effect in relieving phthisis.

Mr. W. E. STARLING quoted a quack advertisement. Pine forests had been recommended in phthisis. Phthisical patients were clear complexioned and handsome. He thought all highly bred animals were more liable to disease. Fresh air was important, but it was important not to wait till the last stage to make use of it.

Mr. RUDD warned men against the blue gum tree. In Ceylon it was going to dry up marshes and cure disease; it was planted and found to be a delusion. He wished to know whether, when ether reached the stomach it evaporated and produced a cold in the bowel.

Mr. PALMER thought more should have been said about the prophylactic treatment. He wanted to know whether the advice given to narrow-chested and thin boys to take plenty of exercise, as football or rowing, was judicious, and what exercise should be recommended.

Mr. PRICE thought cricket not advisable. He knew of a case that after severe bowling coughed up much blood, and this occurred several times. That rest in the south of England, without violent exercise, but gentle outdoor exercise, had restored the patient to health.

Mr. BERRY said that not sufficient emphasis had been laid upon hereditary history, but there was difficulty in many cases in getting the history. He thought phthisis might skip over a generation, and so render history more doubtful. He believed in the good appearance of phthisical people, and mentioned that in diseases above the diaphragm people looked hopeful, and below were generally depressed.

Mr. DOWNES thought little progress had been made in the treatment, that Mr. Flanagan had taken the infective side and not the constitutional; that there was the hereditary form, and another in which the patient catches cold and dies in seven or eight weeks, tubercle not having yet been developed. He thought husband and wife were subject to the same external influences, and did not get the disease one from the other. Of 500 to 600 cases in most cases the tubercle was in both lungs. If the inflammatory origin were true, there would be more cases of one lung being affected. The term phthisis originally had nothing to do with tubercle, but to any wasting disease of the lung.

Mr. E. A. STARLING wanted to know what phthisis was. The author of the paper had discussed the pathology, had spoken about tubercle, but had not told them what it was. He mentioned a case in which a patient had had fistula, been operated on and cured, and had no phthisis. He thought digitalis useful in hœmoptysis.

Mr. BAYES thought it unfair to condemn Mr. Flanagan for leaving out facts from his paper. Tubercle affects the lymphatic system, and this favours its constitutional origin. Ol. Morrhuæ upsets the stomach, and is often of questionable value.

After a vote of thanks to the reader of the paper, the meeting adjourned.

DIALYSIS AND DIALYSED IRON.

Dialysis is a species of osmosis, that is a diffusion or passage of fluids through organic membranes. The late Thomas Graham to whom we are indebted for the first knowledge of the law of diffusion; divides bodies in respect to their diffusibility, into two classes, one of these he termed crystalloids being mostly crystallisable substances or closely approaching them in character. The other class he denominated colloids which are uncrystallisable of a glassy or horny structure when dry (like gelatine, &c.,) and generally of an insipid taste. These two classes of bodies may be almost entirely separated from each other by placing the mixture containing them on one side of an organic membrane which is in contact with water on the other. A double osmosis then takes place; from one side the crystalloids pass through the membranes into the water and from the otherside water passes into the mixture. The ratio of diffusion is universely proportional to the densities of the liquid on either side; a dense liquid will pass slowly; a dilute liquid or pure water more rapidly. The colloid subtances, however are not absolutely retained on one side; they also pass through the membrane but at so slow a rate that the crystalloids may nearly all have penetrated the membrane before an appreciable amount of colloids has accompanied them.

The apparatus employed for this process is generally constructed in the following manner:—a light hoop of wood or of gutta-percha about 2 inches deep and 5-10 inches in diameter is covered with a piece of moistened bladder or parchment-paper, so as to form a sieve like vessel. This apparatus is called the dialyser. This is floated upon a quantity of pure water contained in another larger vessel. If the colloid substance remaining in the dialyser be our chief object it is best to employ a large quantity of water at once; the crystalloid bodies pass into this in the form of a dense solution which sinks to the bottom and causes the lighter unsaturated water to be constantly pushed up towards the membrane. If however we want to separate the crystalloids, to the neglect of the colloids, we must use as small a quantity of water as possible.

Dialysed Iron is a preparation which has attracted the attention of many members of the medical profession, and the experience resulting from its use is so satisfactory that it promised to become one of the most valued therapeutic agents in a large class of diseases where the ordinary iron preparations are objectionable.

The following is a process by which it may be prepared:—Take 10 parts Liq. Ferri Perchlor. (B.P.), precipitate by Liq. Ammoniæ, and wash the precipitate thoroughly. Mix this with 12 parts of Liq. Ferri Perchlor (B.P.) and place in a dialyser. The dialyser is placed in a suitable vessel with distilled water, the water under it renewed every 24 hours.

The operation is continued until the dialysate ceases to contain chlorine, at which time the preparation is found to be neutral. It usually takes from 12 to 15 days to complete the process. The resulting preparation is of a deep dark red colour, and contains 5 per cent. of oxide of iron. As to the chemical condition of the iron in solution, M. Bravaise of Paris (who claims to produce the only genuine), says, "It consists of liquid peroxide of iron, *i.e.*, iron merely united with oxygen and water to the exclusion of all acids," but it is, in

act a neutral solution of an oxychloride of iron in a concentrated form, and the theory of its production is nothing new, and is very simple.

The oxychloride (which is the substance retained in solution in the dialyser) is a colloidal substance. The chloride (which is the principal substance rejected or washed out as it were) is a crystalloidal substance. These two substances—crystalloid and colloid—are separated by dialysis, the former from the latter by diffusion through a septum, such as parchment paper.

The solution of dialysed iron mixes perfectly with distilled water but is precipitated by common water; it is also miscible with alcohol, glycerine, syrup, &c. Tannin added in small quantities darkens the solution somewhat, and on filtering leaves but little matter in the funnel; on using a stronger solution of tannin a well diffused gelatinous precipitate takes place having a deep brown, but not a black colour and the filtrate is colourless. Solution of nitrate of silver added in small quantity does not disturb the transparency of the liquid: on adding more of the former a gelatinous brown precipitate takes place, and the colourless filtrate is free from iron, but the addition of distilled water causes the precipitate to dissolve again. Apparently, therefore, the solution is free from chloride; but on adding first a slight excess of ammonia, filtering from the ferric hydrate, acidulating with nitric acid, and then testing with nitrate of silver; a white precipitate of chloride of silver is formed. The acids nitric, sulphuric, hydrochloric, phosphoric, &c., give precipitates in solution of dialysed iron. The solution is best given by itself upon sugar or mixed with some simple syrup which is free from acid. The dose is from 10 to 30 minims.

HENRY COLLIER.

EXAMINATION NEWS.

ROYAL COLLEGE OF SURGEONS.

Final Examination.

The following gentlemen were admitted members at the recent examination:—H. A. Baber, A. G. Collington, E. B. Granger, J. F. MacCrea, W. A. Phillips, J. K. Womersley, P. R. James.

The following passed in Surgery only:—G. F. Crooke, H. Bovill, J. Tabb, O. Griffiths, C. St. J. Wright.

First Fellowship.

The following Guy's men passed the late examination:—W. T. Crewe, A. Pain, J. H. Morse.

UNIVERSITY OF LONDON.

The following is a list of the Guy's men who have passed the recent Second M.B.:—

First Division.

R. E. Carrington, H. Davy, T. S. Sheldon, J. C. Uhthoff.

Second Division.

M. Lubbock, E. A. Paddison.

Honours.—Medicine.

First Class.

Carrington, R. E. (Gold Medal).
Uhthoff, J. C.

Second Class.

Davy, H.

Obstetric Medicine.

First Class.

Sheldon, T. S. (Gold Medal).
Uhthoff, J. C.

Second Class.

Davy, H.
Carrington, R. E.
Lubbock, M.

Forensic Medicine.

Uhthoff, J. C. (Scholarship and Gold Medal).
*Carrington, R. E.

* Obtained the number of marks qualifying for the Gold Medal.

Second Class.

Davy, H.

Third Class.

Sheldon, T. S.
Paddison, E. A.

Correspondence.

The Editor wishes it to be distinctly understood that he is not in any way responsible for opinions expressed by Correspondents.

To the Editor of the "*Guy's Hospital Gazette.*"

Dear Sir,—Will you allow me, as one of one of the Consulting Physicians, of whom "an undergraduate" writes, to assure him that we are very sensible of our deficiency in the treatment of functional diseases, and very anxious to supply it from the experience of general practice. But if some of us are too fond of publishing our supposed discoveries, are not those who in this matter are able to treat as too averse from it? However, there can be no more welcome contributions to our "Gazette" than letters from Guy's men in practice who will teach us how to cure head-aches and colds and "minor aches and pains which may render life miserable."

I should like to add a few words on the interesting remarks by the same writer, which appeared in your August number, under the heading *Similia Similibus curantur.*

(1.) There is no "orthodoxy" in medicine. Its facts are those of anatomy and pathology, and like all scientific facts can be questioned by anyone. Its practice is based on the combined experience of many observers in many countries, and at many times, and no results of experience can be "heterodox," for orthodoxy and heterodoxy have reference to opinion and authority, not to argument and fact.

(2.) With respect to Homœopathy, "an undergraduate" gives up half of Hahnemann's system as "absurd irrational, infinitesimal dosage." Why then is it "surprising bigotry" to be prejudiced against the other half? Moreover, although no one probably prescribes infinitesimal doses many pretend to; and the public believe that giving a small dose of quinine instead of a large dose of bark, or a small dose of tincture instead of a large dose of infusion of digitalis is "homœopathic," practice.

(3.) The principle on behalf of which he pleads for quarter, "Similia Similibus curantur," is not so much false as unmeaning. It is the last of the many similar "principles" of free Scientific Medicine, equally, but not more, illogical than the rest. If an undergraduate will think what he means by the word disease, and how he could apply the "principle of similars" to its simplest and best understood examples*, he will soon be convinced that homœopathy like the other dead

*Vomiting from pregnancy, vomiting from tumour of the brain: diarrhœa from arsenic, diarrhœa from cholera poison: constipation from hernia: blindness from tumour, blindness from cataract: aphonia from aneurism, from hysteria, from cartarrh: pruritus from scabies, pruritus om jaundice

and gone "systems of medicine," is not so much a wrong answer to a question as a blunder in putting the question. The public are told that there are two systems of medicine, Allopathy and Homœopathy, and since they cannot judge of their truth they must judge by their results or by their pleasantness. But Allopathy (if anyone professes it) would be quite as irrational as Homœopathy. The delusion would be the same, that we can get at the results of Therapeutics by the short cut of a dogma instead of by the beaten road of experience. We can all see how castor oil may sometimes cure constipation, and sometimes cure diarrhœa, but we give it in both cases on no *a priori* "principle" but by the light of physiological knowledge applied by common sense. In the nature of things there can no more be a universal principle for doctoring the human machine when out of order than for doctoring an irregular clock or a leaky pump. A "homœopathic" practitioner then, though he prescribes the same drugs and the same doses as other people, commits these great fatal mistakes. He is guided by a theory, which is demonstrably not erroneous, but absurd. He treats symptoms instead of investigating them. He treats diseases instead of treating patients. He hunts after specifics, which shall cure infallibly no one knows how, instead of searching for method of treatment, which shall restore by intelligible means, and point to prevention as well as to cure. It would be wrong to call such a man a knave or a fool. It would be wrong to apply such terms to Holloway or Morrison, or Raspail. He is simply a survival of past ages, who meddles with an art of which he has not mastered the elements.

I am, Sir, Your obedient Servant,
A GRADUATE.

TO THE EDITOR OF "*Guy's Hospital Gazette.*"

Dear Sir,—In your last issue you made some remarks as to the presence of first year's men in the Operating Theatre and Out-patients' room. I have attended operations frequently myself, and have never yet seen the Theatre overcrowded. I have noticed, however, that men, more especially Senior men, have a habit of accumulating round the door: if, instead of doing so, they were to distribute themselves about the Theatre, I think we should hear less of the Senior men not being able to see what is going on. With regard to the Out-patients, I am in the habit of attending there also, and have never yet had the pleasure of seeing the crush of men you speak of. I would also remind you that many of the Freshmen have already passed a considerable period at a Provincial Hospital, or as pupils to a surgeon, and have, perhaps, seen as much practice as many of the third year's men. These can hardly be supposed to understand nothing of what is going on. I should think occasional attendance at operations, &c., on the part of Freshmen, was rather a thing to be rejoiced in; it at least shows that the men take an interest in their work.

Hoping that in justice to the Junior men you will insert this. I am, Sir, Yours truly,
A FRESHMAN.

TO THE EDITOR OF "*Guy's Hospital Gazette.*"

DEAR SIR,—As one of the Senior Students, naturally interested in all that concerns my Alma Mater, my attention was early drawn to the Training Home attached to the hospital. Its working and usefulness were points that then engaged serious attention, and from the experience of the last six months I have come to the conclusion that the whole thing, as a training school, is a *failure*. It has long been the wish of many of us that a training school for nurses should be carried on here, so that when we afterwards are in practice we should be able to send to Guy's for a well-trained and reliable nurse. But why has this been a failure? We can enumerate many reasons. In the first place the home was started on a wrong principle. There should have been at its head a trained lady superintendent, who should have had entire control over the home. The inmates should have been made subject to the same rules as the nurses, and while in the wards under the authority of the Sister.

According to the present arrangement we see, wandering about in an indefinite sort of manner, ladies fancifully attired, changing their wards and occupation at pleasure, and seemingly answerable to no one for the work they do.

Instead of coming to the wards at seven o'clock in the morning, and having their allotted share of work to do in a given time, as any other probationer, they appear between nine and ten, when half the real nursing work, especially of the surgical wards, is over. They seem to amuse themselves by playing at taking temperatures and dressing cases, in the majority of instances requiring a nurse to assist and clear up after them.

Surely they have come here to learn *nursing*. To be a thorough nursing sister requires an early, careful, and stringent training. No one is competent to act as such unless she knows thoroughly, from personal experience, the duties of those under her. The best nurses are not of a necessity those who have the most intimate acquaintance with the subjects of anatomy or physiology, or the greatest skill in the dressing of wounds.

"No nurse is worthy of her high calling who hesitates to perform for her patient any absolutely requisite service, however disagreeable; and though it is not generally needful for a lady to perform menial work, it is necessary she should know how to do it when need suddenly arises, if she intends to stand in the first class of nurses."

Yours truly,
NOX.

PNEUMONIA.—The proposition made by "Pneumonia" has several times been discussed in the *Gazette*. He should send his name to the Editor, not necessarily for publication.

THE IMPORTANCE OF A KNOWLEDGE OF ELECTRICAL MANIPULATION.

The rapidly increasing use of Electricity in medicine and surgery renders it important that the professional man should become sufficiently well acquainted with the science to enable him to manipulate the different kinds of electro-therapeutical instruments that have been introduced from time to time.

But Electricity, as an accepted auxilliary to the physician and surgeon, is of such comparatively recent date that but few are able efficiently to use a continuous current or induction instrument, although with their usual liberal spirit most have become possessed of one or other of those sold. Experience, however, in its use has been such as to lead them, with much disappointment, speedily to place it aside as requiring too much attention to ensure its good action.

In hundreds of instances, both in hospital and private practice, have I seen expensive apparatus lying useless from this cause, and it is this experience, doubtless, which has caused that very elegant (but least useful) form of machine the magneto-electric battery to become so very popular, as it requires simply a handle to be turned to generate the electric action.

Some of the old fashioned batteries are certainly troublesome to keep in order, and complicated in their management, needing almost daily attention, but those of modern construction have been greatly simplified and rendered so easy of manipulation that any intelligent lad could soon manage them faultlessly.

It is not even safe without a certain amount of electrical knowledge to purchase an electro-medical or surgical battery. Manufacturers as a rule simply knowing they have batteries for sale, but of the varying physiological effects of the different currents given, they are entirely ignorant. I have known instruments giving induction currents repeatedly sold as constant current batteries, although the purchaser, having his doubts, has mentioned them to the seller. Electricity, they say, is Electricity, no matter what be the form of battery generating it, is perfectly true so far, but the *quality* of the electricity, which is of primary importance, is not the same, but varies with the different forms of batteries; and it is a knowledge of these varying properties thus conferred upon the electricity and their applicability to different forms of disease that ensures successful results. We are constantly having patients in the electrical department who have been galvanized, as they term it, for months without benefit, and in most instances with the magneto-electric machine, but on using that kind of current experience has proved most suitable to their case, satisfactory results have been obtained.

The many enquiries constantly being made at our rooms plainly indicate the existence of a general desire for such practical information, which must ultimately render it incumbent on the medical school to give instruction in the manipulation of electrical apparatus, enabling the student to distinguish the different forms of batteries, and discover and remedy any little defect that may occur in use.

I have been repeatedly told the therapeutic application of electricity needs no science to be brought to bear upon it, on the contrary, I believe this is the very requirement, and the more strictly scientific the application, the more successful the operation. For in practice it is found the quality, quantity, and direction of current, duration of time, and points of application, are items of the highest importance, and in proportion as improved construction of apparatus enables us to measure and regulate these, little peculiarities of response, which at present are taken no notice of, will become more marked, and their right interpretation will considerably increase the diagnostic value of electricity.

Many times I have been solicited by enquirers to write a small text book on electrical manipulation, and through the kindness of the Editor of this journal the opportunity now presents itself. I purpose to give, in as concise and condensed a form as possible, in a series of monthly papers, a description of the electro-medical and surgical apparatus in Guy's Hospital and their *modus operandi*.

The first paper will appear in next month's *Gazette*. I shall be pleased to answer any enquiries through this paper bearing on this subject. H. P. SEYMOUR.

FOOTBALL NEWS.

GUY'S HOSPITAL v. LONDON SCOTTISH.

This match was played at Blackheath, on Saturday, November 23rd, and after an hour's play resulted in favour of the Hospital by one goal to nothing. Guy's losing the toss, Stokes kicked off against wind, and till up to half-time the only advantage gained by either side was two touchdowns to Guy's. During this half Stokes made a very good drop, which just missed the post. After ends had been changed Guy's gradually pressed their opponents back, and Stokes gained a try, which, however, was disputed, and brought back. Directly after this Jackson get in between the posts, and Stokes kicked a goal. The crowd greatly interfered with the game, and were more than usually obnoxious.

For Guy's: Jackson, Stokes, and Long behind; and Browne and Lister forward, played well: while

For London Scottish: Burton and Scott were in fine form.

London Scottish. R. Arnot, J. Gow, J. Moffat, N. MacGlastran, J. C. Sutherland, W. D. Little, W. Davidson, A. Whyte, J. Wilson (forwards); W. Scott and C. Grant (half-backs); T. J. Wright and G. W. Burton (three-quarter-backs); G. M. Thompson and W. Grieve (backs).

Guy's. J. H. Lister, J. J. Boswell, A. A. Jeyes, J. A. Fraser, R. Cuff, H. Mead, H. Whyte, L. A. Dunn, Browne, E. Hunt (forwards); A. H. Jackson and T. W. J. Long (half-backs); L. Stokes (three-quarter-back); H. Blatherwick and J. B. Howell (backs).

GUY'S v. RAVENSCOURT PARK.

This match was played at Blackheath, on Saturday, Nov. 30th. Guy's won the toss, and Ravenscourt kicked off against the hill: the ball was well returned by Blatherwick, and Boswell obtained a try close to touch. The kick, a difficult one, failed. Ravenscourt then, touched down, but Guy's playing very well together, again forced them back, and Lister, after a maul, obtained a second try, which, however, again failed. Soon after this Jeyes had a maul, but as there seemed no likelihood of either side getting the ball it was brought out five yards. The next try for the Hospital was obtained by Veitch, and from this Lister kicked a goal. Half-time was now called. Ravenscourt, with the hill in their favour, made a better fight, and several good runs were made by their backs. The last advantage gained by either side was another try for the Hospital by Cuff. The kick, however, only resulted in a poster. Guy's thus won the match by one goal, three tries, and six touchdowns to nothing.

The place kicking of the Hospital was to say the least of it poor, though in other respects they played very well.

Ravenscourt Park. Pawle (Captain), Bere, Davis, Lagden, Hugull, Davison, Hebert, Stewart and Marriott (forwards); Sapte and Davison (half-backs); Grimshaw and Hugull (three-quarter-backs); Paliolagus (back).

Guy's. J. H. Lister (Captain), J. J. Boswell, A. A. Jeyes, W. Growse, R. Cuff, L. A. Dunn, Hunt, Hickman, T. R. Atkinson and J. Anderton (forwards); E. H. Harvey and T. W. J. Long (half-backs); E. Dixon and Blatherwick (three-quarter-backs); J. B. Howell (back).

SECOND FIFTEEN.

GUY'S II. v. ST. GECRGE'S II.

Played at Blackheath, October 25th. After a rather rough and stubbornly contested game, we obtained two goals and and one try to nil.

GUY'S II. v. ST. BARTHOLOMEW'S II.

Played at Blackheath, November 9th. As we were playing University 2nd on the same day, our teams were necessarily rather weak, but in spite of that we held our own, each side obtaining a try and two touches.

GUY'S II. v. ST. THOMAS'S II.

Played at Lambeth, November 16th. Resulted in our favour by one goal, one try, and six touches to one "dropped" goal. For the first half the game was very one-sided, our opponents not being in it, but after half-time affairs were more even, St. Thomas's doing their best to retrieve the game, but in vain. The second try was obtained by Dixon by a maul in goal, in which he wrested the ball from three St. Thomas's men and touched it down.

GUY'S II. v. ARABS II.

Played at Blackheath, November 23rd. For the first time this season we turned up two short, and as our opponents had brought a very strong team against us we suffered defeat, the score being two goals and two tries to nil. Play did not begin till nearly four o'clock, and after three-quarters of an hour's play the game was abandoned, owing to the darkness which rapidly set in.

GUY'S II. v. LONDON HOSPITAL II.

November 27th.

GUY'S II. v. KING'S COLLEGE HOSPITAL II.

November 30th.

Neither of these matches came off, as our opponents could not get up a team.

NOTES OF THE MONTH.

Amongst the events of the past month it is our painful duty to record the untimely death of one of our fellow students, Mr. James Thomas Bishop, who succumbed to a most severe attack of typhoid fever on the 11th November. Until the commencement of his illness he had been acting as Medical Ward Clerk under Dr. Pavy, and had gained, as in his previous work, at once the goodwill of his teachers no less than that of his patients. Wisely electing to place himself under the care of Dr. Habershon, in Clinical Ward, he progressed fairly well for a few days, but owing to various complications he became worse and was removed, by the kind permission of the Treasurer, to the private room in Clinical. His illness, however, presented still more unfavourable features, and terminated fatally on the 18th day of the fever.

THE GLEE CLUB.

This Club is to be continued this Session, and already the applicants have been very numerous, though there are still vacancies for tenors. All institutions which tend to knit men together are surely to be encouraged, and more especially one which like this has for its object the cultivation of such a valuable social art as singing.

Mr. Stanley Taylor resigns this year his post as Conductor. He has been connected with the Club for four years, and is now only leaving at the termination of his career at the hospital. He bears with him the good wishes of all who have known him.

A Concert is to be given to the inmates of the Hospital early in January, vocal and instrumental, and judging from the last an enthusiastic audience may be counted on.

SALICYLIC ACID SNUFF IN HAY-COLD.

The following appears in the *Louisville Medical News*. It won't do to swallow or snuff up everything one sees in print. Even so veracious a journal as the *Louisville Medical News* may lead into error. Last week you published among the selections an extract from the BRITISH MEDICAL JOURNAL, in which was related the experience of "W. J. H. Wood" with salicylic acid in hay-fever. He used the acid as a snuff, given pure, to the amount of "ten or fifteen grains daily." I innocently gave the prescription to a patient, who, after trying it, asked if it were not a "little strong." Whereupon, having said "Oh, no," I illustrated my faith with works, and took a pinch myself. Shades of Macaboy, of Rapee, of Cayenne pepper, of all mixed! Faint and puny outlines are ye of the "salicylic acid pure." Was my faith shaken? Yes, my friend, and the very foundations of the house in which I stood, by the sneeze which followed the snuffing of that innocent looking powder. I said I thought *it was* a little strong, and would have it diluted. And now a most curious sequel: I took that powder to a drug-store (there were about forty grains of it) and had successively stirred into it a drachm of bismuth, half-an-ounce of powdered gum arabic, a lot of borax, and a handful or so of powdered slippery elm, and at no stage of the proceeding was there any compound which could be snuffed without fear of sneezing one's eyeballs loose. Indeed, I might say, as the result of no little anxious experimentation, that the snuffing of all ordinary and many of the extraordinary dilutions of salicylic acid is far worse than the majority of hay-colds. "W. J. H. Wood's" patient (he had one who liked the acid) was evidently copper lined.—Yours,

NO-MORE-IN-MINE.

P.S.—You will be glad to learn that the drug-clerk, upon whom most of my latter experiments were conducted, is recovering, though slowly.—*British Medical Journal.*

Mr. A. G. Lacy, lately one of our House Physicians, has been awarded one of the medals of the Royal Humane Society for saving the life of a bather at Guernsey.

Several coats, &c., belonging to the Dressers in the Surgery having been missed from the splint room, adjoining the Surgery, detectives were employed to find the culprit. This resulted in the thief, a woman named Mary Hands, being arrested and committed for trial at the Old Bailey. She used to come to the Surgery on various pretences, generally to have a tooth extracted, and when no one was watching, go to the splint room and remove the coats. It seems that she is well known to the police, and was wanted by them for some other thefts. Unfortunately, owing to some flaw in the trial, this swindler was acquitted.

THE READING ROOM.

On Friday, 22nd inst., a Meeting was held in the Anatomical Theatre to consider the formation of a Reading Room. Mr. C. Knox Shaw in the Chair. It was proposed to have a Reading Room in the Hospital, for the use of students. It was to be independent of the library, and to have all the daily and weekly papers, and to be open to subscribers. A Committee was elected to settle the necessary affairs, and to lay them before another General Meeting. The following gentlemen were elected:—Mr. Ryle, to represent the first year, Mr. G. N. Pitt, second year, Mr. R. Scott, third year, Mr. A. Scott, fourth year, Mr. E. Penny, fifth year, Mr. R. Steele, sixth year. Mr. Knox Shaw was also elected on the Committee, and Mr. Pitt was asked to become Secretary.

A Committee Meeting was held on Tuesday, the 26th inst., when the rules were discussed, and it was resolved to submit them to a General Meeting as soon as convenient.

The cost of the antiseptic system has, says the *Lancet*, excited the serious consideration of the managers of the Glasgow Royal Infirmary. Our own authorities have also found that since its introduction into Guy's there has been a large increase in the yearly expenses. We do not see how this can well be avoided, and shall watch with great interest the result of the investigations at the Glasgow Infirmary, to see whether they can find a way out of the difficulty.

NEW GOVERNOR.

At a General Court of the Governors, held on the 13th ultimo, The Lord Bishop of Rochester was elected a Governor in the room of the late Mr. Joseph Lawrence. Guy's Hospital, by recent Ecclesiastical legislation, is now situated in the Diocese of Rochester.

TESTIMONIAL TO THE LATE TREASURER.

We hear that it is in contemplation by some of the Governors and the members of the Staff, to subscribe towards the placing of a portrait of Mr. Thomas Turner in one of the panels of the Court Room.

Books and Pamphlets received:—"The Doctor," "The Sanitary Record," "The Students' Journal," "The Medical Press and Circular," "The Proceedings of the Medical Society of King's."

APPOINTMENTS.

The following appointments were made by the Medical Council on November 21st, 1878:—

Obstetric Residents.—E. B. Granger (December), E. J. Morley (January), Charles Wood (February).

Clinical Assistants.—A. E. Maylard, G. H. West-Jones, R. Parry, R. W. White, H. E. Wright, P. M. Wood.

Dressers.—R. R. W. Oram (Mr. Cooper Forster); F. F. Jones (Mr. Bryant); H. H. Austen, A. K. Morgan (Mr. Durham); T. B. Cross, A. Scott (Mr. Howse).

Dressers in the Eye Wards.—T. W. Fuller, M. J. Hart, E. Penny (January and February).

Medical Ward Clerks.—E. J. Plummer, W. J. Parkinson, J. F. Tabb, R. J. H. Scott, J. T. Brett, W. P. Bothamley, H. A.

Clowes, J. S. Crook, C. H. Downes, E. O. Jago, T. H. Morse, G. C. S. Perkins, F. S. Pilkington, H. A. Phillips, J. S. Smith, S. T. Thomas.

Assistant Surgeons' Dressers.—A. H. Langridge, H. E. Archer, G. R. Marsh, H. P. Rowlands (Mr. Davies-Colley); J. Anderson, J. Smith, L. W. K. Phillips, J. M. Prendergast (Mr. Clement Lucas); E. R. D. Fasken, F. W. Pilkington, J. R. Rolston, W. W. Pryn (Mr. Golding-Bird); A. P. Hills, F. M. G. Smith, W. T. Crew, G. J. Wilson (Mr. Jacobson).

Assistant Physicians' Clerks.—J. Cock, W. H. Crosse (Dr. Fagge); E. Roper (Dr. Pye-Smith); W. P. Morgan, S. H. Moore (Dr. Goodhart); C. J. Harper, O. B. Shelswell (Dr. Taylor).

Obstetric Out-Patients' Clerks.—H. H. Sturge, N. E. Johnson-Gaylor, J. W. Sanders (first half); W. P. Morgan, (second half).

Obstetric Ward Clerk.—E. Roper, R. Steele.

Dental Surgeons' Dressers.—J. F. Tabb, D. C. Trott (January and February).

Aural Surgeon's Dressers.—J. W. Meek, E. Fielding, H. H. Sturge, P. St. G. Williams, S. W. Moore.

Post-mortem Clerks.—H. H. Bovill, H. Charles (December and January); E. T. Cockell, H. W. Gosse (January and February); O. B. Shelswell, W. Whitworth (February and March).

Assistant Surgeons' Clerks.—F. E. Row, F. Pearse (Mr. Davies-Colley); C. W. Bowles, F. H. Shanks (Mr. Clement Lucas); E. R. B. Archer, C. Y. Shuter (Mr. Golding-Bird); W. T. F. Davies, A. M. Sutton (Mr. Jacobson).

Dressers in the Surgery.—H. Charles, J. H. Harris, F. T. Bayes, A. Hind, F. O. Combe, M. D. Gilkes, B. N. Rake, G. J. Cressy, E. Elliott, H. Gard, N. E. Johnson-Gaylor, A. L. Lane, A. S. Stokes, J. W. Woodruff, John Rigby, S. Edwards.

Surgical Ward Clerks.—H. D. Davenport, L. Burroughs, W. E. Hearnden, A. L. Lane, A. S. Stokes, B. Suder, E. G. Williams, H. T. Bassett, W. H. C. Newnham, R. H. Browne, D. G. Edwards, H. P. Keatinge, J. H. H. Williams.

Messrs. J. M. Hobson and W. Lane have been appointed Assistant Demonstrators of Anatomy.

ON DUTY FOR DECEMBER.

House Physicians, E. Clifford Beale, G. Mackern. *Junior House Physician*, J. C. Uhthoff. *House Surgeons*, J. Hammersley, C. Knox-Shaw. *Junior House Surgeon*, R. S. Wainewright. *Senior Resident Obstetric*, R. R. W. Oram. *Junior Resident Obstetric*, E. B. Granger.

RESIDENT DRESSERS.

December 4th.—Mr. Alexander (Mr. Bryant).
" 11th.—Mr. West-Jones (Mr. Durham).
" 18th.—Mr. Hale White (Mr. Howse).
" 25th.—Mr. J. A. Howell (Mr. Cooper-Forster).

GURNEY HOARE PRIZE.

The above prize of £25 for Clinical Study has been awarded to Mr. Charles Wood.

ELPHANTIASIS.—Dr. Manson, of Amoy, has discovered that this disease is caused by the presence of the filaria sanguinis hominis in the lymphatic vessels, disordering their functions, blocking their channels, hence the formation of Elephantoid tissue, lymph-scrotum, chyluria, &c. The mosquito is believed to be the occasion of the prevalence of the disease in the far East; it gets the filaria from man. The parasite propagates in the insect's stomach, whence it is discharged into water; whence again its progency is taken up by man.—*Proceedings of the Medical Society of the County of Kings.*

APOTHECARIES' HALL.

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George Henry West Jones.

PRIMARY EXAMINATION.

Robert Parry.

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